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VOLUME 55 SEPTEMBER 1940 NUMBER 3

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Just in Passing—

A FULL and well-illustrated report of the Boston conventions of the American Hospital Association and allied groups will be one of the principal features of the October issue. Hospital people have come to look forward to these convention reports as authentic and comprehensive pictures of a convention that has grown too large for any one person to cover.

A WEALTH of excellent material awaits small hospital readers in October. Dr. H. M. Bishop of Saginaw, Mich., has written the article that is the answer to every administrator's prayer. It deals with the medical staff. A. A. Aita of San Antonio Community Hospital, Uplands, Calif., has set down an informal account of small hospital administration; it loses nothing by being amusing. Contributors to the Small Hospital Forum for October will talk over x-ray service. The editor will present his monthly Little Journey and there is accumulating an interesting set of Small Hospital Questions.

LEWIS H. STONEMAN has been making tests of public opinion regarding hospitals and will present his results next month.

READ AND PASS ALONG

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Administrator		
Purch. Agent	.....	.....
Supt. of Nurses	.....	.....
Surg. Supervisor	.....	.....
Dietitian	.....	.....
Housekeeper	.....	.....
Pharmacist	.....	.....
Engineer	.....	.....
Laundry Manager	.....	.....
Radiologist	.....	.....
Pathologist	.....	.....
Chief of Staff	.....	.....
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.....	.....	.....

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The Modern Hospital

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The central sterile supply room at San Pedro Hospital, San Pedro, Calif.

Worth Trying, Anyway

• Here is an idea for you to talk over with your local newspaper people. What happens to all the books that stream across the editor's desk for review or possible serialization? Wouldn't it be a generous gesture on the part of the newspaper office to distribute such volumes among the hospitals of the community?

That's precisely what the *Philadelphia Inquirer* did. Each month a new hospital was selected as the recipient of a book donation, the subjects covering a wide range — poetry, economics, philosophy, travel and fiction. An attractive bookplate was prepared bearing the inscription, "Reading makes the time pass quickly—presented by the *Philadelphia Inquirer,* an independent newspaper for all the people."

Excellent publicity for the newspaper because, in addition to the inscription, the presentation of the books each month is a good feature story. And what hospital hasn't need for more and better books!

Hospital Hobby Show

• We wonder if Newton Hospital, Newton, Mass., is going to put on another of its hobby shows this fall or early winter. If so, a trip that way will be well worth while.

It's a community affair, everyone with a hobby is eligible—staff doctors, their families, staff nurses, friends and employes. Its purpose, and there could be none better, is to give the public an opportunity to become acquainted with the doctors and the hospital personnel as thoroughly human individuals who have interests outside their professional work. Last year the opening of the show, which was staged in the basement of the nurses' residence, was timed for the interns' annual reunion. The show ran for two days during which more than 1800 people came—and wondered.

Most everyone has a hobby these days. If they haven't, they should. A show will stimulate interest, even to the extent of making the hospital a hobby. Who can tell?

That Central Supply Room

• Are you thinking of putting in a central supply room? Before doing so take a look at the one that Mary J. Currie, administrator of San Pedro Hospital, San Pedro, Calif., recently installed. Also listen to her words of advice.

"One section should be installed where unsterile supplies enter and are separated, and another for sterile supplies where they are issued. This ensures greater safety. This room should connect with the stock room. It should have compressed air, sterile distilled water and a warming cabinet for sterile solutions kept at 99° F. temperature. Be sure to include deep shelves with sliding doors, also, as well as deep drawers to hold the heavy packs and drums.

"This room should be air conditioned and should be well lighted by outside windows and overhead light. Work tables should be 3 feet high. Equipment should include rest back stools, nurse's desk, typewriter, telephone, sewing machine, Bunsen burner, small instrument boiler, sink with hot and cold water and requisition blanks. All treatment trays and sterile dressings are requisitioned from this department. The central supply room can be operated satisfactorily in connection with the surgical department inasmuch as the autoclave can be installed here."

Some Light on Ink

• Did you ever stop to consider how much ink is used and wasted in your hospital? Frank B. Gail of West Jersey Homeopathic Hospital in Camden, N. J., figures that in his institution, which has approximately 300 beds, 12 dozen quarts of red and black ink are consumed at 76 locations. This estimate, he finds, is quite uniform, but adds: "You must remember that we use ink twenty-four hours each day in the year. The medical charts are voluminous for each patient who is in the hospital for an average stay. The students make use of it in their classroom work and, without doubt, the doctors fill their fountain pens."

It is evaporation that plays havoc with consumption, however. It is estimated that 2 ounces of ink evaporate in an open well every three weeks. When it is considered that the ink is being used in some 76 stations, the total year's evaporation runs to something like 83 quarts. Covers are provided, of course, but it is hard to keep them closed and they become lost and are not replaced.

So in West Jersey Homeopathic they have installed an entirely automatic, self-closing type of well. These are more expensive at the start, but economical in the long run because they reduce waste.

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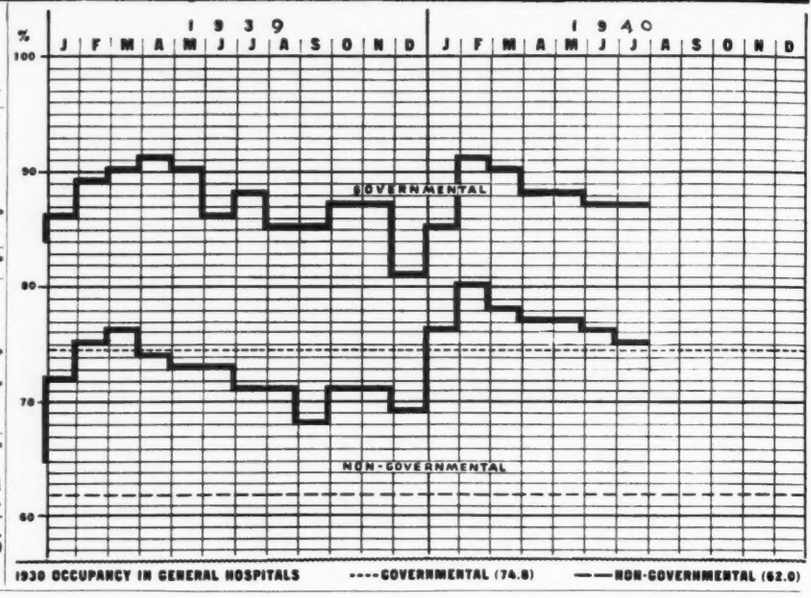
HOSPITAL OCCUPANCY BAROMETER

Type and Place	Census Data on Reporting Hospitals: Hosp.[1]	Beds[2]	1940: July	1940: June	1939: July	1939: June
Governmental:						
New York City	17	10,439	101*	101	96	102
New Jersey	4	2,625	96*	96*	86	85
N. and S. Carolina	18	2,387	74*	75	72	72
New Orleans	2	3,824	81	83	114	112
San Francisco	3	2,255	96*	96	93	90
St. Paul	1	1,180	69*	69*	66	70*
Chicago	2	3,500	90	90	91	91
Total[4]	47	26,210	87*	87*	88	87*
Nongovernmental:						
New York City[3]	68	15,194	76*	76	71	76
New Jersey	61	8,131	79*	79*	68	70
N. & S. Carolina	109	7,538	66*	67	68	69
New Orleans	6	1,126	83*	81	79*	75*
San Francisco	16	3,178	75*	75	73	76
St. Paul	9	1,103	75*	75	68	72*
Chicago	17	3,716	65*	72	65	69
Cleveland	9	1,336	81*	81*	79	80
Total[4]	295	41,323	75*	76*	71*	73*

[1]Excluding hospitals for tuberculous and mental patients and institutional hospitals. Census data are for most recent month. [2]Excluding bassinets, usually. [3]General hospitals only. [4]Occupancy totals are unweighted averages. *Preliminary report. Complete occupancy figures for January 1933 to November 1939 are given on page 1010 of The Eighteenth Hospital Yearbook.



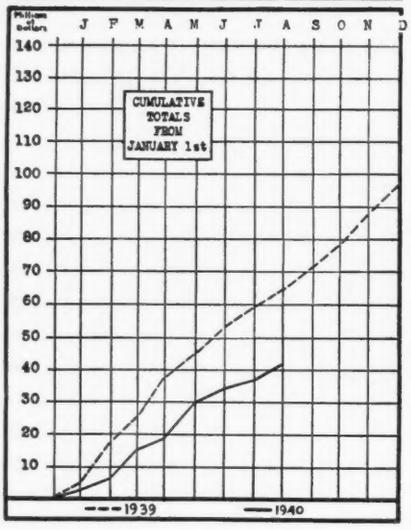
Occupancy Records Broken in First Seven Months in 1940

Occupancy in the nongovernmental general hospitals dropped another point in July, according to preliminary figures available at the time of going to press. This brought the July occupancy down to 75 per cent. Final figures may bring it still lower. For the first seven months of 1940 the average occupancy in this group of hospitals is 77 per cent. Last year during the same period the average was 73 per cent; in 1938 it was 71 per cent and in 1937 it was 72 per cent.

The current year is a record-breaker so far as occupancy of the voluntary general hospitals is concerned. It should be pointed out, also, that in many of the reporting communities the hospitals have increased their capacity so that the base upon which these occupancy percentages are computed has increased. The actual increase in hospital utilization is, therefore, even larger than the increase in the percentages would indicate.

In the reporting governmental general hospitals occupancy remained unchanged from last month at 87 per cent. The average for the first seven months for these hospitals is 88 per cent this year as compared with 87 per cent last year. Occupancy continues at a high level in the hospitals belonging to the city of New York, although it is down somewhat from the peak reported in April and May.

HOSPITAL CONSTRUCTION



Thirty-five hospital construction projects were reported in the period from July 15 to August 12, inclusive. Costs were given for 32 of these, which aggregated $4,566,732. This brings the total value of new construction reported since January 1 to $41,200,000 as compared to $64,900,000 during the same period of last year.

The 32 new hospital projects reporting costs were distributed as follows: 7 new hospitals to cost $496,500; 23 additions to existing hospitals to cost $4,005,232 (three other additions did not report costs); one alteration to cost $30,000, and one nurses' home to cost $35,000.

General wholesale prices as reflected in the index of the *New York Journal of Commerce* eased off slightly from 78.8 on July 13 to 77.8 on August 17. Grain prices dropped during this period from 60.5 to 58.3, continuing the marked recession that started when Germany marched into the Low Countries in the second week of May. On May 11 this index stood at 82.2. General food prices fell from 67.6 on July 13 to 63.4 on July 27 but then recovered to 66.2 on August 17. Textiles declined from 67.4 to 65.6 during the month. Fuel prices also declined.

The price of building materials, on the other hand, moved from 97.5 to 98.4, having dropped during the spring and early summer from a peak of 101.3 last December. The price index on drugs and fine chemicals compiled by the *Oil, Paint and Drug Reporter* continued to drop from July 15 (203.8) to August 12 (203.2) but then jumped slightly to 204.3.

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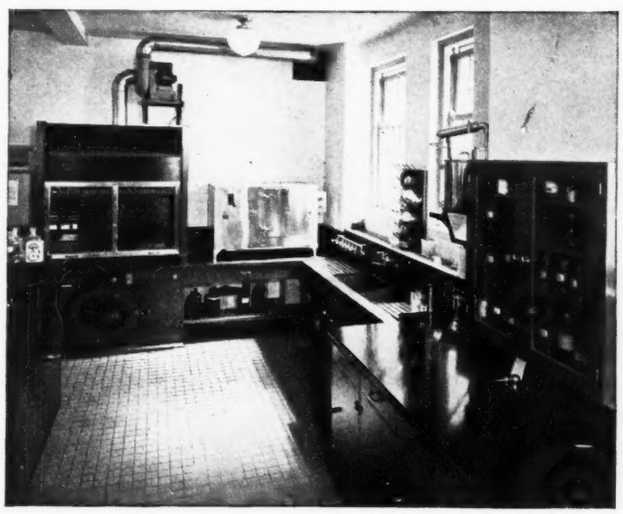

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SMALL HOSPITAL QUESTIONS

This department is conducted with the cooperation of Gladys Brandt, R.N., Cass County Hospital, Logansport, Ind.; Alloys F. Branton, M.D., Willmar Hospital, Willmar, Minn.; Mrs. Jewell W. Thrasher, R.N., Frasier Ellis Hospital, Dothan, Ala., and others

Instructing Personnel

Question: Should small hospitals attempt to give definite instructions to new employes? Should these cover anything more than merely the duties of their positions?—D.B.P., Ky.

ANSWER: The philosophy and course content of training should be the same, irrespective of the size of the hospital; size determines only methods and technics. In small hospitals instruction must be more personalized and less formal and regimented.

Training should permit an opportunity for the orientation of the new worker into the hospital scheme. A brief review of the history of the hospital, its organization and place in the community should be presented. The economic, social and esthetic factors of each position as it relates to the whole are as important as the actual functions of the job itself.

Definite instruction should be given in deportment, carriage, dress, attitudes and approach. "What to do" and "what to say" are important; "how to do it" and "how to say it" are apparently even more important.—E.C.H.

Preparing Solutions

Question: What is a simple method of preparing and storing large quantities (from 2 to 4 gallons) of salt solution and boracic acid solution used in daily irrigation for genito-urinary patients?—G.B., Ind.

ANSWER: A simple and satisfactory method is to prepare 5 gallons of boric acid solution at one time. The solution is then transferred to 32 oz. square, wide-mouthed bottles, capped with a rubber diaphragm and then sterilized. For identification purposes the solution is colored with gentian violet. These bottles are sent to each floor and replaced every five days, if they are not used. Salt solution can be handled in the same way.—G.U.W.

Fuel for Cooking

Question: How can we decide whether to cook by electricity or by gas? What fuel is the majority of hospitals using?—E.J.S., Kan.

ANSWER: Gas is perhaps the most widely used cooking fuel. Improvements in gas cooking equipment have eliminated many of the bad features. Some people believe that gas is faster and that electricity is cleaner. The low electric rate in many communities has increased the popularity of electricity for cooking. Each can be costly because of extravagance and carelessness. The community rates of gas and electricity should be a deciding factor. Some institutions use a hard coal stove, which operates at a very low cost.—G.B.

Shaking Mops

Question: We have no yard or place for a dust chute and the disposal of the quantities of lint that gather on dustmops is a real problem. Are there any suction machines or other type of mop cleaning equipment on the market that could be installed on each floor, without too great expense?—R.C.S., Calif.

ANSWER: A homemade dust receptacle that has proved very satisfactory is a garbage can with a hole, just large enough to accommodate the mop handle, cut in the cover. The rim of the hole is bound with rubber (part of an old automobile tire will do) to eliminate noise. The handle of the mop is thrust upward through the cover, the cover is replaced on the can and the mop is thoroughly shaken without scattering dust.—D.L.D.

Shock Treatment

Question: What is your opinion of the desirability of administering metrazol treatments to mental patients confined in a 24 bed convalescent home?—E.S.L., Ill.

ANSWER: The treatment of mental cases with metrazol has been confined to patients who are suffering from chronic depressions and to certain of those suffering from schizophrenia. In my experience the treatment has been satisfactory in the treatment of depressions but of little permanent benefit in the schizophrenic reaction group.

The treatment should be given only in completely equipped hospitals. Most convalescent homes do not have adequate emergency facilities for the safe administration of shock therapy. Because there is great danger of fractures it should be used in connection with some buffer system, such as curare injections or insulin coma. Needless to say, the treatment is complex and dangerous and should be administered only by physicians who have had thorough training in the method. Depressive cases require anywhere from three to ten treatments, which can be given in a space of approximately three weeks.

There is a definite risk involved. The principal complications are fractures of the vertebrae or of the long bones. These fractures can usually be prevented by curare injections and can be minimized by orthopedic appliances.

In certain instances deaths from intracranial hemorrhages have been reported but we have been fortunate enough to avoid this complication. Neuropathological studies have shown that the treatment produces definite changes in the central nervous system but there is usually no clinical evidence of this damage.

Most of the depressive cases who improve maintain their recovery from the particular attack but, of course, all depressions are likely to recur. The results that are sometimes obtained in the schizophrenic reactions are usually transitory and in my experience a relapse has been the rule rather than the exception.—F.G.E., M.D.

Hot Food for Patients

Question: How can we keep our meals hot until they reach the patients? What are the relative advantages of central service and floor service for an 80 bed hospital? How long, on the average, should we hold cooked food before it is served?—L.N., Neb.

ANSWER: For direct tray service, food is served from containers that have been kept hot in a heated cabinet directly onto hot plates, which are placed in a heated compartment in food trucks. For indirect tray service, containers of food are placed in insulated boxes, in which they are taken to ward diet kitchens. Containers are then placed in steam tables in which food is kept warm until the serving is completed.

Cooked meats, *i.e.* steaks and chops, may be placed on hot plates or in heated containers for a period of from 20 to 30 minutes from the time of preparation to the time of serving. Roast meats may be handled in the same way but from 30 to 45 minutes may elapse from time of carving to serving time. Vegetables may be placed in heated containers or on hot plates for about 30 minutes from time of preparation to time of serving.—E.D.U.

LOOKING FORWARD

A Welcome Addition

THE appointment of Dr. S. S. Goldwater as the active executive head of Associated Hospital Service of New York is important news. It is a further indication that hospital service plans have now become so important that they are able to enlist the full-time services of the leading men in the hospital field.

Doctor Goldwater's acceptance of his new post is welcome news from another angle also. He has long been a forceful exponent of the desirability of extending hospital service plans so that they would reach farther down the economic scale. Both executives and trustees of other plans that are concerned with this problem—and virtually every plan in the country is so concerned—will welcome the addition of Doctor Goldwater to their counsels. He brings a wealth of experience in medical, public health, hospital and governmental service that is unmatched in the United States.

The best guarantee that voluntary hospital service plans will continue to flourish and will meet the real needs of the community is the fact that these plans have enlisted the services of many men who bring to their problems a broad social viewpoint as well as business acumen. Successful voluntary hospital and medical plans are the best defense against governmental plans. But such "success" must be measured in community as well as in financial terms.

Nursing Controversy

IT IS popular today among certain hospital administrators to damn the accrediting program and the revised curriculum for schools of nursing. The advancing costs of nursing education and the actual or potential shortages of nurses for graduate floor duty present real problems. The fee of $250 for accreditation also has been an object of criticism.

While it is easy to criticize, the more thoughtful administrators are looking beyond these immediate points in the program of the National League of Nursing Education and are considering the long range objectives. It is obvious that the standards of nursing education that were acceptable a few years ago are acceptable no longer. Nurses today are expected to perform technical tasks of which their predecessors never dreamed. As the scope of medicine has broadened, the physician has had to delegate more and more duties to the nurse.

Better trained nurses are becoming too expensive for use as glorified maids; hence, the development of ward aids or trained attendants to relieve the nurse of nontechnical duties. Undoubtedly, such workers will increase in number and will avert or mitigate the threatened shortage.

Ultimately, nursing education will probably be taken over in large part by universities and similar institutions just as has education in other professional fields. Perhaps only in this way can nursing education attain its proper stature. We do not object to the education of doctors and dietitians being provided by outside agencies with hospitals used as laboratories for practical experience. Isn't the time coming when we should accept the same practice in the nursing field?

Last month The MODERN HOSPITAL published a pair of articles on the accrediting program that ought to be studied thoughtfully by every hospital administrator who has responsibility for a school of nursing. Miss Allen's article is especially noteworthy because it stresses the intangible values received by the school. "Although the visitors sent by the accrediting committee did not suggest changes in the program," she said, "they established a feeling of rapport that encouraged stimulating questions and interchanges of opinion." In view of her comment, criticism of the fee for accrediting seems rather petty.

A Revealing Procedure

IN A recent article, A. S. Redway, vice president of a large machinery factory in Connecticut, reported the surprise that came to him and other executives of

the corporation when a job-rating plan was undertaken. The company had for many years made a practice of paying wages equal to or exceeding the prevailing rates for comparable jobs in its particular community. It checked periodically with other companies and increased any rates that were found to be low. But let Mr. Redway tell the story.

"So certain were we of the satisfactory condition of our wage structure that it seemed like a waste of time to go into an elaborate job rating plan, but we thought it might be interesting to prove that our rates were correct. Imagine our surprise when the results showed that 28 per cent of our jobs (about 18 per cent of our wage earners) were underpaid from 10 per cent to 20 per cent. I don't mean that they were underpaid in comparison with wages in other plants but with those for other jobs in our own plants. Needless to say, we put job rating to work."

Although similar in purpose and principle, job rating in industry differs rather widely in details from job rating in hospitals. Persons who are interested in applying job grading to hospitals will find excellent suggestions in the article by Dr. Gertrud Kroeger, which appears in the 14th edition of The *Hospital Yearbook*. The job descriptions recently published by the American Hospital Association committee on personnel relations will also prove helpful. Any hospital that employs 100 or more employes, and even smaller institutions, will find that a careful job grading is well worth the effort.

Intern and Resident

IT IS not to be expected that the report of the Commission on Graduate Medical Education, which was recently distributed to hospitals, medical schools and other interested groups, will effect an immediate revolution in the internship, the residency and postgraduate medical education. The report advocates no revolution. Its suggestions look toward gradual but persistent change.

An analysis of the report by Dr. Malcolm T. MacEachern and his associates in the American College of Surgeons finds that the recommendations for graduate education "are wholly in accord with those of the American College of Surgeons in their application to graduate training in general surgery and the surgical specialties." By its aggressive and alert action the college has carved out for itself an important field of usefulness in the accrediting of surgical residencies.

Many physicians on the staffs of hospitals have considered interns and residents as high grade flunkies whose function is to make the life of the staff doctor easier. The commission's report vigorously stresses the true educational functions of these two periods. As occasion arises, more and more staff members will read the report and will realize the importance of organizing the work of the intern and resident so that it may give these young doctors the best possible preparation for their subsequent medical practice. The true measure of the worth of such a report cannot be taken in a month or a year but only in a decade or longer when it can be evaluated in terms of its results.

Hospital administrators may well call the report to the attention of the leading physicians of their staffs and suggest that it be reviewed and discussed at staff meetings or in journal clubs.

New Load for Rural Hospitals

THE projected expansion of the United States Army means that large training camps will be established in spots at a considerable distance from the major metropolitan areas of the country. From 50,000 to 100,000 men may suddenly be brought into an area that ordinarily boasts a much smaller population.

While the Army will doubtless set up its own temporary hospitals, it seems probable that for the more serious medical and surgical conditions it will call upon the existing community institutions. Certainly, there will always be the chance that emergencies may require the use of civilian hospitals.

The plans of the War Department are changing so rapidly that it is difficult, if not impossible, to obtain any information from Washington that can be relayed to local communities. Administrators of hospitals that are near Army encampments should, therefore, check with the local military authorities as soon as possible to determine what demands, if any, may be put upon their facilities and should take appropriate steps to meet these demands.

The Quality Called Morale

THE most costly and stately hospital cannot provide safe care of the sick unless zeal, spirit, confidence and hope are generously inherent in the institution's personnel. Clinicians and psychologists believe that a sick man whose morale is high is much more likely to conquer his malady than is the despondent, beaten individual. Somehow, a high morale manifests contagious tendencies, one worker emulating his fellow, the patient emulating the doctor or the nurse.

Whence comes this abstract, yet highly desirable quality? Probably it emanates from the office of the hospital executive who is understood and appreciated by a wise board of trustees. Its seeds are an evident interest in the welfare of all, a disciplinary firmness and yet, withal, a fairness that refuses to stoop to favoritism.

Morale, also, has its commoner physical components, *i.e.* wholesome food and a light, airy space in which to eat it; good sleeping and recreational quarters, and a fair compensation. Morale is certainly not the child of fear of punishment or of a blind adherence to rules. One of the outstanding traits of a good executive is a manifest ability to build a high morale among the employes of the institution.

The Price of a Bed

H. O. COLOMB, M.D.

Do mental hospital beds come at $9 or $2315? This is the simple story of a simple bed in a mental disease institution. When it comes to special beds, that is a different matter

AT FIRST glance, one would not expect the cost of a bed to be very high. After all, a bed, especially a single bed, is not a complicated object. However, when we qualify it as a "hospital" bed it begins to mean something more and if we add the adjective "mental" it means an additional something.

Let us start with a simple iron pipe, flat spring, white enameled bed, 30 inches wide and 6 feet long. Being a mental hospital bed, the spring does not sit in slots at the head and foot but has to be bolted at these points to keep it from being taken apart.

Like any other bed, it must have a mattress. In addition, there is a protective rubber sheet and the usual quota of cotton sheets, a blanket, a spread, a pillow and a pillow case. To keep the bed clean, there must be additional sheets, blankets and pillow cases while the soiled ones are in the laundry. So far, although the bed itself cost only $8 or $9, we begin to see that this serves only as the center around which expenditures begin.

To be of use, the bed must stand somewhere, so we come to the matter of floor space. Regulations require that we allow 50 square feet of floor for each bed and, if it is to be occupied by someone who should have a single room, then 80 square feet must be given over to its use.

This does not end the problem because we now come to the individual who occupies the bed. The building in which he resides is his home and, as in any home, he must have his living room, which standards prescribe as another 50 square feet per patient. The patient has to eat and regulations say he must have at least 15 square feet of space in the dining room. He must also keep himself clean, attend to his natural functions, get up and down stairs, have a corridor to get about in the building, have at least semiprivacy when his relatives come to call and be able to see his physician in an office or examining room when necessary. In addition, there must be some place in which his food can be cooked. For all of these purposes, there is an additional 38 square feet of space necessary.

Some of these patients are able to go to amusements and to indulge in recreation, so there must be a seat in the amusement hall for the less disturbed patient to sit in while he watches plays and moving pictures and a seat in the bleachers for him while he watches the ball game. But let's omit these for a time; still we find that our $9 bed, with its occupant, now commandeers 153 square feet of space.

Experience shows that a simple building to take care of this bed and its occupant and to give the occupant living room without any great degree of privacy can be built for $2000 per patient if we make it large enough to take care of at least 150 patients. So aside from buying a simple inexpensive bed and its equipment, the space and utilities must be supplied to go with it.

To go back to the occupant, for each patient, an average of 300 gallons of water a day will be consumed for which provision must be made. Each patient will need 1/3 h.p. at the power house to supply him with light, heat, cooked food, hot water and the necessities. Adding to the power house to produce this need costs $100 per patient, for when we say "bed" we really don't mean "bed," we mean "patient."

The patient's bed clothes and his own clothes must be kept clean and we know from experience that each additional patient adds another 100 pounds of laundry to the load. To increase the capacity by this much means a capital expenditure of $15 per bed. Also, to take care of the occupant of this bed, we must have some place to store his food, clothing and supplies because such things are bought in quantity to save money. Many of these "beds," taken together, consume a great deal of food. For example, the consumption of eggs in an average sized mental hospital (2500 beds) is something over 400 dozen for one meal. For these purposes, each bed must have its 7½ square feet of space in the storeroom.

After we have added the beds we have, besides the capital expenditure, a regular recurring cost of maintenance, to say nothing of depreciation. For every additional 150 beds, there must be another doctor, six trained nurses and 15 hospital attendants, in addition to other employes to handle office work, work on the farm and utilities. This added cost for 150 beds is about $120 per day.

To summarize, let us consider in dollars and cents what it means to add 150 beds to a mental hospital.

Capital expenditures for living space for 150 "beds" at $2000	$300,000
Power plant additions	15,000
Laundry	2,250
Kitchen, recreational, vocational, storage	30,000
Total	$347,250

The average cost per "bed" is $2315, to say nothing of that original $9 we spent for the bed.

This is a simple story of simple beds. Add the adjective "specialized" to make it "specialized mental hospital bed" and we find that the cost of space is no longer $2000 per bed but that for space only, the capital expenditure per "bed" is as follows:

Medical and surgical	$6000 ea.
Acute admitting service	3500 ea.
Tuberculosis	3500 ea.

Then to add to the headaches, if the institution is overcrowded, if the beds have outgrown utilities and if upkeep has been poor, you can average the cost of each bed at $4800.

Don't let the term "bed" fool you; it means more than it says.

Doctor Colomb is assistant superintendent of Philadelphia State Hospital, Philadelphia.

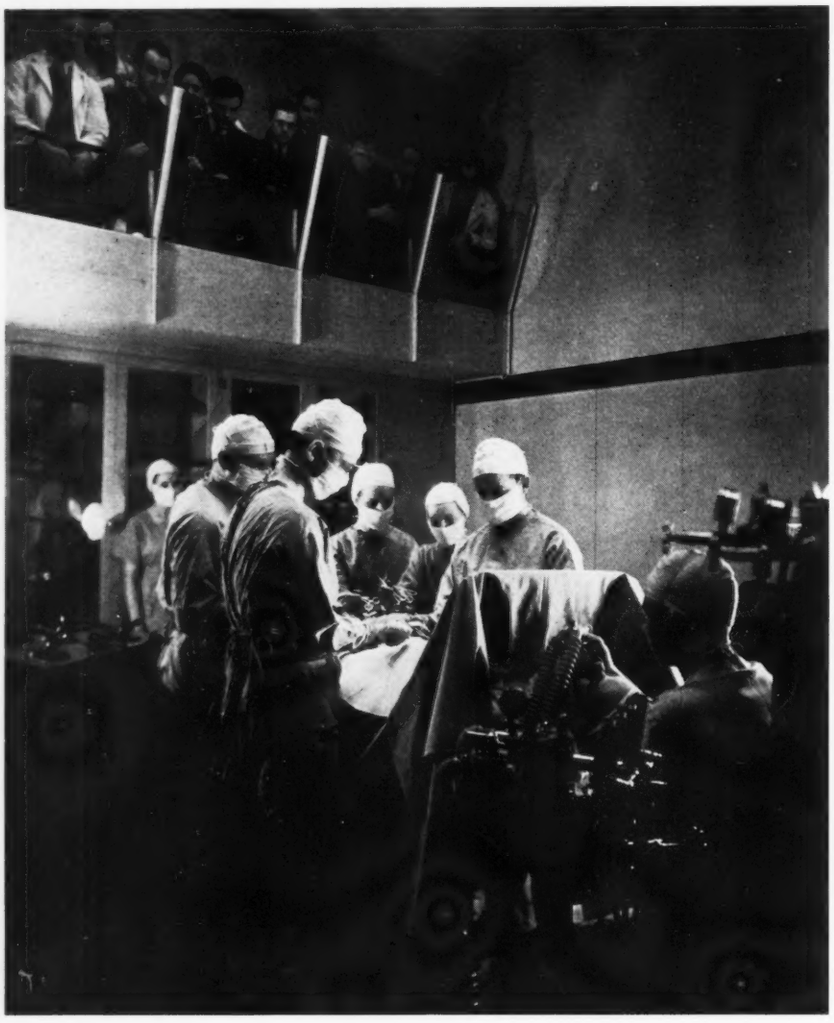
FRASER D. MOONEY, M.D.

Buffalo Likes Its

FOR many years Buffalo General Hospital, Buffalo, N. Y., operated two operating suites, one on the first floor and the other on the fourth floor. For many reasons this arrangement was unsatisfactory and in the fall of 1938 plans were drawn in which all surgeries were brought into one suite. The old fourth floor surgery was entirely revamped and was connected to the new construction.

In the new section the six operating rooms are on the south side of the corridor. There are no windows in any of these rooms both because natural daylight interferes with the artificial lighting and because the additional wall space was needed. Each pair of operating rooms is connected by a sterilizing room at the south end of the operating room and a scrub room at the north end. Walls are 15 feet high and are lined to a height of 8 feet by green carrara glass with a border of black glass. In the south wall where windows would ordinarily be placed is a pair of clocks, a stop clock for timing operations and an electric clock of the usual type. Below them is a battery of x-ray viewing boxes.

At the south end of each of these rooms is a gallery for medical students or doctors who wish to witness the operation. Persons who use this balcony enter from another floor and do not pass through the operating room floor proper. The balcony is separated from the operating floor by plate glass so that witnesses of an operation need not be capped, gowned or masked. Under the balcony are cabinets for surgical instruments.



Each room has a lighting unit that covers practically the entire ceiling and consists of 21 lenses, each lens backed by a 200 watt bulb. The light is directed downward so that about 1000 foot candles of light are shed on the operating field.

Each room is equipped with water suction and air pressure and the two rooms in which most of our nose and throat work is done are equipped with mechanical suction. The pump is located in the basement.

Behind each operating room door is a foot switch connecting with a panel signal box in the medical secretary's office across the corridor. When the surgeon is ready to "sew up," the nurse presses the switch; this indicates the room number in the secretary's office and she comes to the door of the surgery, takes the dictation and has the operation report ready for the surgeon's signature by the time the operation is completed.

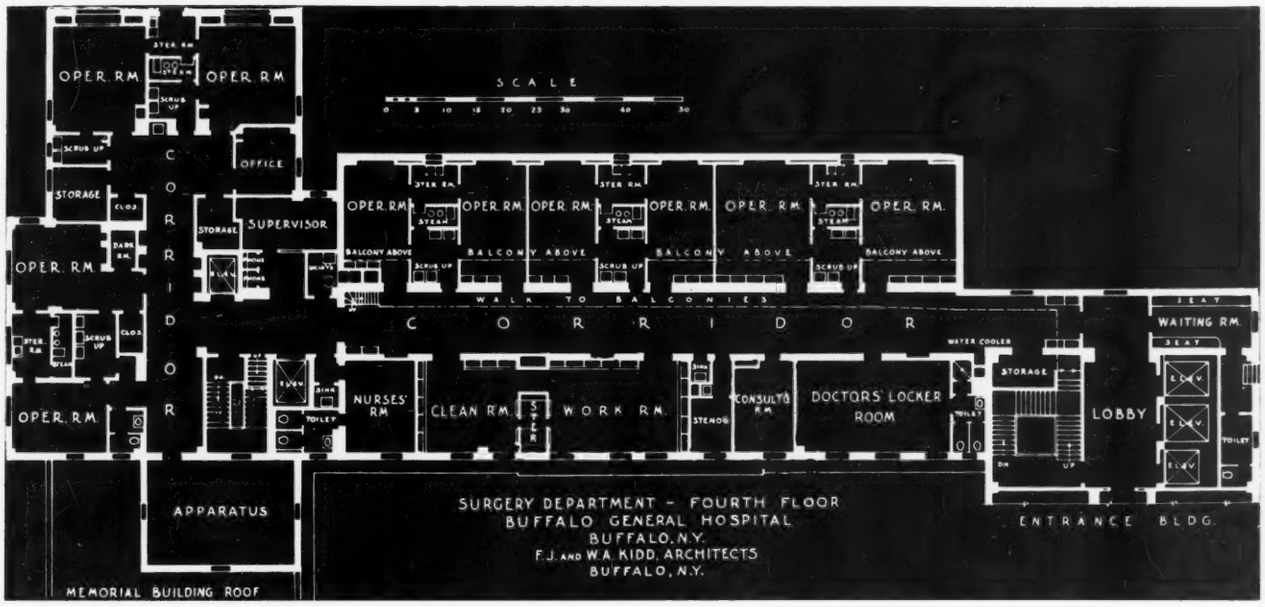
These six rooms are air conditioned. The temperature is kept between 76° and 80° F. and the humidity, from 50 to 55 per cent. Humidity is checked at regular intervals with a sling hygrometer and we believe that the air is so wet that it obviates most of the danger of ignition of explosive gases by static spark.

In the old surgery one central set of scrub sinks supplied scrubbing facilities for all four rooms. The new system provides scrub-up and sterilizing rooms adjoining each surgery. The sterilizing rooms contain instrument and water sterilizers, as well as blanket warmers and solution warmers.

The ceiling type of lighting was not used in the scrub-up and sterilizing rooms because of the additional expense of installing it and also because it was the consensus that so much heat would be given off by the necessary number of light bulbs that the room temperature could not be controlled without installing an air conditioning unit.

Modernized Surgery

Superintendent, Buffalo General Hospital, Buffalo, N. Y.



The walls in these rooms are also green. Here we used pressed wood with a baked enamel finish. It cost about one tenth of the carrara glass and if it does not stand up as well as we wish it can be replaced at a small cost. This was an experiment as was the glass, but both have now been used eighteen months and are perfectly satisfactory.

The north side of the corridor comprises a large locker room with adjoining toilet facilities and showers; a consultation room; the medical secretary's office; the supply and workroom; the nurses' dressing room, and a storage room. In an alcove at the entrance of the secretary's room is an electric refrigerator in which all surgical specimens are placed until they can be taken to the laboratory.

The storage room, commonly called the "wood shed," is used to store only equipment that is constantly in use, such as carts and stretchers. Here also are stored portable lamps, which, incidentally, are seldom used in the rooms that have been equipped with ceiling lights. Other storage spaces are scattered throughout the surgery.

The supply and workroom is divided into two parts by the walls enclosing a giant sterilizer. All unsterile equipment enters this room through the east door, is wrapped, placed in the sterilizer and, after the required time of sterilization has elapsed, is removed at the west end of the sterilizer and placed on the shelves. Hence, all materials on the east side of this wall are unsterile and all on the west side are sterile. Only materials that are to be used in the surgery are sterilized in this unit.

One operating room has been arranged especially for orthopedics and a splint and plaster room and a dark room adjoin it. This enables us to take x-ray photographs during operations without its being necessary to take these plates to the x-ray department for developing.

The supervisor's office is centrally located and next to this is the station of the telephone girl, who has a complete view of the corridors of the operating suite.

After more than eighteen months' use of this surgical floor, we would make few changes if we had it to do over again. There are a few points, however, that might be brought to the attention of anyone contemplating new construction of this type.

1. When our air conditioning was first installed we found that the air was extracted from the room at a faster rate than it was supplied. This caused a negative pressure in the room so that air was pulled into the room from the corridor. This was obviously bad from the standpoint of asepsis and was corrected so that now there is a slight positive pressure.

2. Plate glass in the balcony should be extended upward and outward for an additional 12 to 18 inches, because a tall person sitting in the front row can, and sometimes does, get his nose over the edge of the glass.

3. While pressed wood with a baked enamel finish is apparently perfectly satisfactory and not nearly as expensive as carrara glass for operating rooms, it is unsatisfactory as a wall lining in the sterilizing rooms. Underneath the pressure sterilizers the baked enamel is beginning to flake off the tiles where they join the sterilizer.

4. Every sterilizing room should have a floor drain. These were left out of all of our sterilizing rooms.

5. It was found necessary to correct acoustics in both the corridor and the workroom. This was done after the surgeries had been in operation for a period of six weeks and eliminated an extremely bad acoustical condition.

Average salaries of engineers vary from one region to another. Higher salaries are paid in the larger hospitals, as well as in Eastern, Middle West and Mountain-Pacific states.

Hospital Salaries—Engineers

ALDEN B. MILLS

THE average hospital engineer in the United States and Canada is paid a salary of $143 per month. As is true in other types of hospital work, the variation in engineers' salaries is wide. Twelve of the 963 men for whom reports were received are paid less than $50 per month. At the other extreme are 15 who receive more than $300 per month. Two of these received more than $400 per month.

The distribution of salaries according to size of hospital follows rather closely the increased responsibilities involved with larger plants. Forty-eight of the 233 hospitals of less than 25 beds reported the employment of engineers. The average salary of these men was $78 per month. This includes the value of whatever maintenance was provided.

There were 325 hospitals of from 25 to 49 beds that sent in reports on The MODERN HOSPITAL's salary study and of these 172 filled in figures for engineers. The average salary of this group was $101 per month. Among the 347 reporting hospitals of from 50 to 99 beds, 290 have engineers, whose average salary is $125 per month.

In the 100 to 199 bed hospitals, of which 303 sent in reports, there are 283 engineers with an average salary for the entire group of $154. All except four of the 106 reporting hospitals of 200 to 299 beds gave figures on salaries for engineers. The average salary of the men in this group is $198.

Forty-four reports were received from hospitals of from 300 to 499 beds and 42 filled in the salaries of their engineers. The average figure for these men was $215 per month. All except one of the 19 reporting hospitals of more than 500 beds reported a salary for the engineer. The average for these 18 men was $272 per month.

It is apparent that the variation in salaries is due primarily to the size of the hospital. But there is some variation also according to location. The average salary in the Eastern states is $163; in the Middle West and Mountain and Pacific areas it is $140; in the South it is $127, and in Canada, $113.

The attached table, however, shows that the geographic differences in salaries paid are due primarily to the differences in size of hospitals. In the seven classes of hospitals shown, Canada pays the lowest salaries in three classes, namely, the under 25 bed group, the 50 to 99 bed group and the 300 to 499 bed group. But in the 200 to 299 bed class, Canadian salaries are practically equal to the highest.

Likewise, the South is lowest in the other four classes but is highest in one, the hospitals of less than 25 beds. The latter figure of $101, however, is based on only four reports and, therefore, may not be representative.

The highest salaries were paid in the Eastern states in only two classes of hospitals, those of from 25 to 49 beds and those of more than 500 beds. The Mountain and Pacific group was also highest in two categories and the Middle West group was highest in one class.

There is tremendous variation in the qualifications of hospital engi-

neers. Some hospitals, even fairly large ones, employ men who have "come up through the ranks" and have learned all they know about engineering by observation, experience and such teaching as they could obtain from their seniors. It would probably be safe to say that most engineers in hospitals, as well as in hotels and similar institutions, obtained their preparation in this manner.

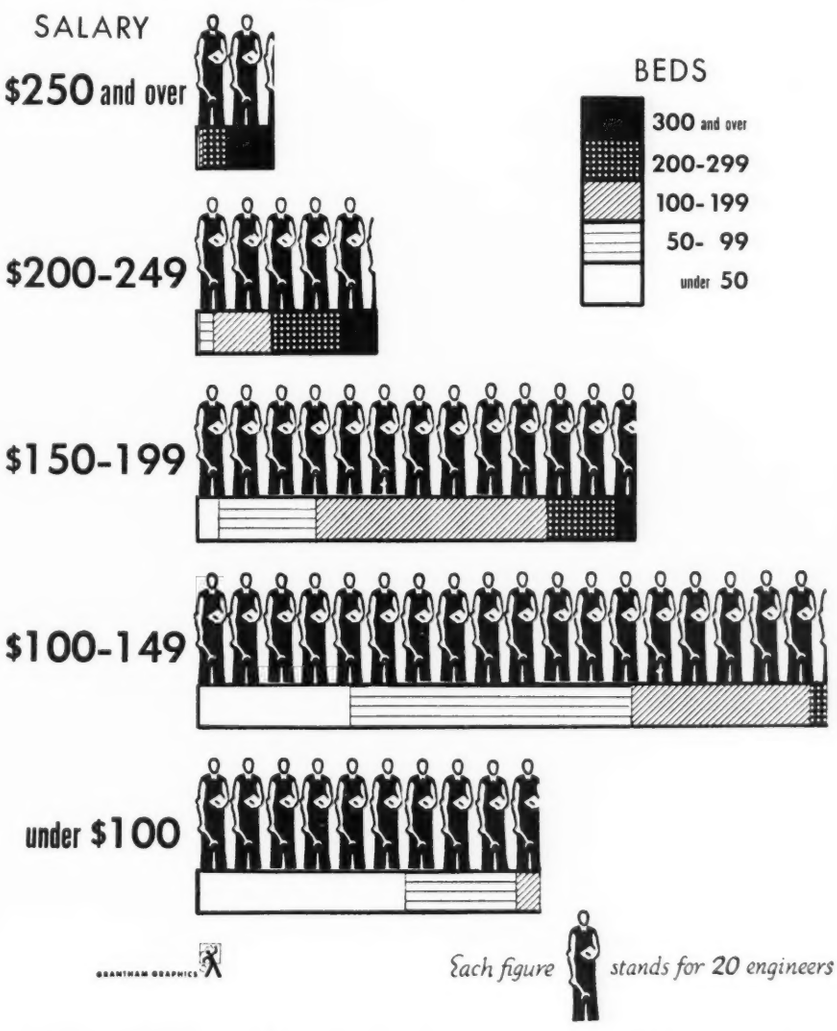
Some of the larger hospitals, however, have employed college graduates in engineering who, after a period of experience in plant operation, are put in charge of the entire physical plant of the institution. Under this arrangement such men have charge not only of the power plant and its appurtenances but also of all repair, maintenance and painting work and sometimes of the laundry and the housekeeping department.

Monthly Salaries of Hospital Engineers, 1940

Area	Size of Hospital *Under 25*	*25-49*	*50-99*	*100-199*	*200-299*	*300-499*	500 *and over*
Eastern	$ 86	$121	$132	$161	$204	$257	$346
Southern	101	82	116	137	165	270**	171**
Mountain-Pacific	92	102	133	175	196	206	...
Middle West	74	98	126	155	208	221	255
Canada	57	90	112	140	207	168**	277*

*Only one report received.
**Only two reports received.

The chief difficulty encountered in following this course seems to be that the salaries hospitals are willing to pay often are not sufficient to retain competent engineers. Either the hospitals must content themselves with the less promising candidates or else these men, after a few years, either leave the hospital field and go into industry or take up hospital administrative work.



Data on salaries of 963 engineers show an average of $143 per month. More reports were received for engineers than for other department heads.

In the recently published report by the A.H.A. committee on personnel relations entitled "Job Specifications for a Hospital Organization" the position of chief of maintenance was described as follows:

"Duties: Under administrative direction, to supervise all mechanical and electrical maintenance throughout the hospital; to supervise all building and ground maintenance, and to perform related work as required.

"Example: Overseeing the installation, testing and repairing of all mechanical and electrical equipment; overseeing all the maintenance work on buildings and on the grounds; seeing that the ventilating, lighting and plumbing systems are functioning properly; requisitioning materials and supplies; preparing reports and recommendations to the hospital administrator.

"Minimum Qualifications: High school education. Preferably college or university graduation. Eight years of experience in maintenance work. Thorough knowledge of modern practice in the maintenance of buildings and grounds. Supervisory ability."

The committee set up a separate description for the position of chief engineer under the heading of "Power Plant." His duties were described as supervision of the power house and performance of related work as required. The minimum qualifications set up by the committee require only a common school education with a first-class engineer's license and at least ten years of power plant experience, of which five shall have been in a supervisory capacity. Under the chief engineer in the power plant are listed engineers, firemen and power plant apprentices.

Plan of the first floor, showing x-ray department and radium rooms. The plans are reproduced through the courtesy of the Architectural Forum Magazine.

New Battleground

EDWIN A. SALMON

THE Memorial Hospital for the Treatment of Cancer and Allied Diseases is now occupying its new home in midtown Manhattan adjoining Cornell University Medical College, with which it is affiliated, and the Rockefeller Institute for Medical Research and New York Hospital. The building occupies the entire block between York and First Avenues and East Sixty-Seventh and Sixty-Eighth streets, directly west of the institutions mentioned.

The special requirements of the building program for this the largest cancer institute in the world were to provide for facilities for the in-patient care of 240 persons; out-patient and follow-up clinics for from 600 to 800 persons daily; special x-ray and radium treatment rooms; extensive research laboratories and teaching facilities, as well as the usual accommodations for administration, service and housing.

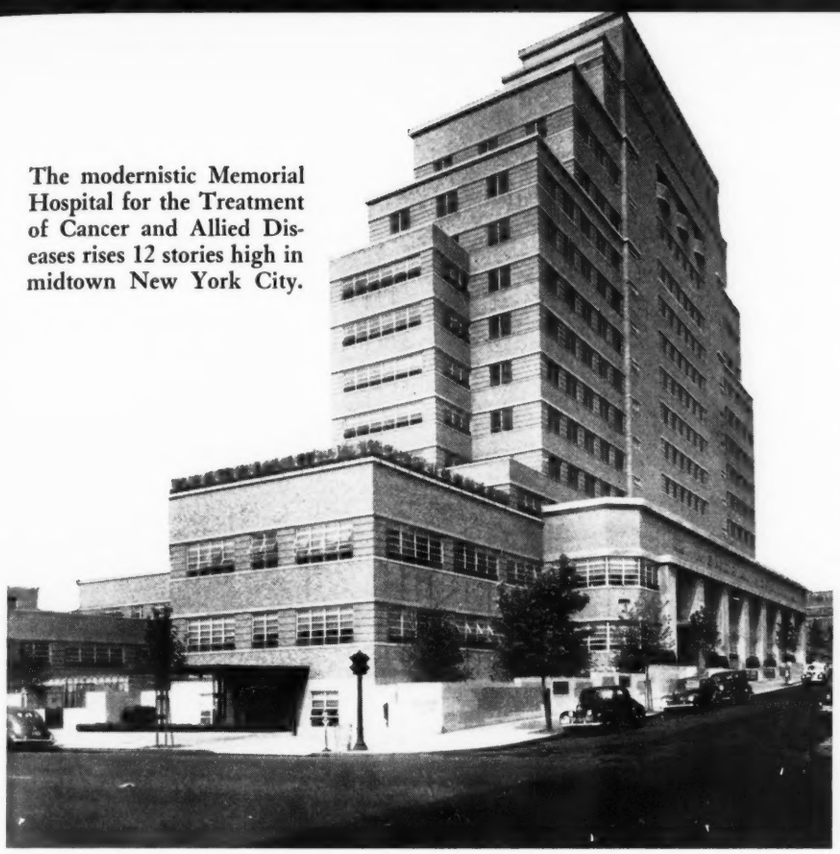
The building was erected in the central and easterly portions of the block, leaving space for future expansion to the west. The functional arrangements required the full utilization of a large part of the ground area on lower floors for general administration, admitting department, clinics, treatment rooms, services and laboratories as related to smaller areas above for in-patient facilities. These basic factors, together with the demand for a maximum of light and air, predetermined a building of two stories and basement covering a large portion of the plot with a 10 story elongated tower running east and west over the northerly section, thus ensuring adequate exposures and outlook.

The architectural character is distinctly modern with a general horizontal motif interrupted by verticals. The exterior is of red brick and limestone with fenestration in continuous horizontal bands. The courts and wings have been developed for the maximum advantages of light, air and outside activities. Roof areas are flat and those adjoining the patients' sections have been developed for heliotherapy and recreation.

The building has two entrances on East Sixty-Eighth Street at the first floor level. The easterly one is a general entrance for all new admissions, visitors, staff and general business and leads directly to the general administrative offices and the admitting clinic, which serves as a triage for all admissions to the hospital services. Each of the eight clinical departments has offices and examining rooms adjoining this section. The departments are: (1) medical, (2) head and neck, including dentistry, (3) breast, (4) gynecology, (5) genito-urinary, (6) gastric and mixed tumor, (7) rectal and (8) bone.

The westerly entrance is for the out-patient and follow-up clinics and leads directly to a large waiting room adjoining various examining and treatment facilities. The head and neck clinic has the largest attendance and, as it requires special equipment, it has been placed centrally and directly off the waiting room. The other clinics utilize the general facilities jointly or alternately.

The two entrance lobbies adjoin the main stem that contains stairs and elevators, the social service departments and the records depart-



The modernistic Memorial Hospital for the Treatment of Cancer and Allied Diseases rises 12 stories high in midtown New York City.

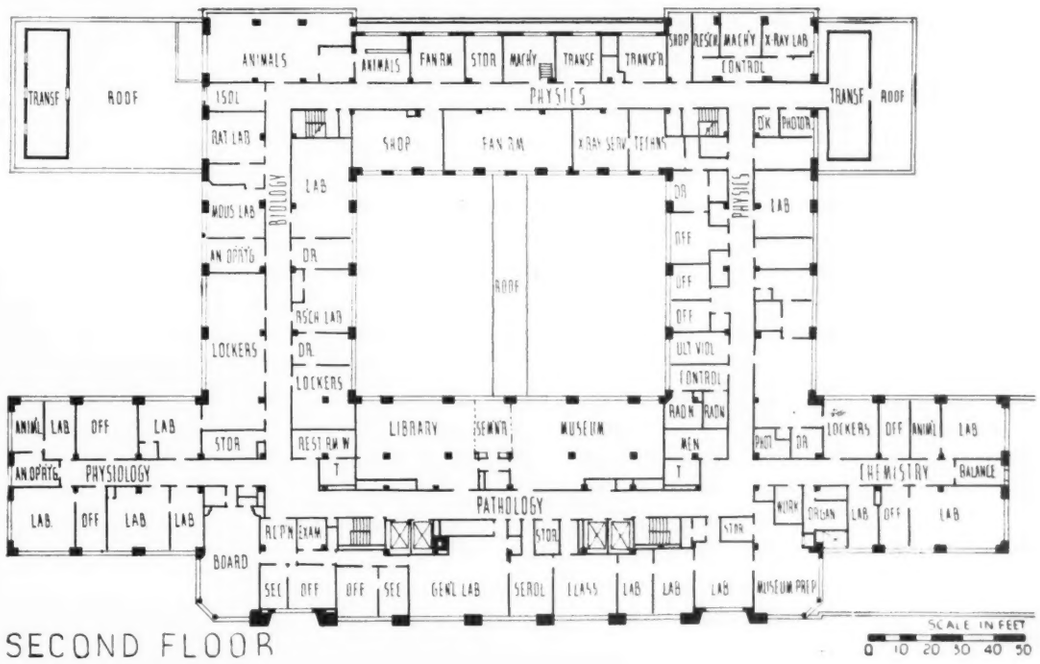
in Cancer War

Architect, Associated With James Gamble Rogers and Henry C. Pelton, New York

ment. Two corridors lead to a wing at the south end of the building containing the x-ray treatment and diagnosis department and radium therapy rooms. In order to avoid cross traffic and intermingling of out-patients, in-patients and general traffic, separate banks of elevators and stairs are provided. Visitors use the group near the general entrance while those near the out-patient entrance are reserved for interhospital traffic. The x-ray department and other central facilities can be reached independently from the admitting offices, the out-patient department and the hospital elevators for in-patients. There is a closer relatilonship among in-patient, out-patient, treatment and laboratory departments in Memorial Hospital than is the case in general institutions because of the protracted care of cancer patients and greater application of all the hospital facilities to each case.

A rapid fall in grade to the east afforded the opportunity of providing a private patients' entrance on the ground floor level on York Avenue, as well as dining facilities for the staff with an attractive outlook on a garden court. The remainder of the basement contains the kitchens, storerooms, laundry, central sterilizing room, necropsy rooms, pharmacy, shops, service rooms and service entrance. A small subbasement houses the machine rooms, motors, transformers and other mechanical facilities. Steam and electricity are purchased from public utilities.

The second floor is devoted to the research and educational departments of the hospital, with the exception of space for the board room and x-ray work shops. The library, museum and department of pathology occupy the central portion and the four wings contain the departments of chemistry, physics, biology and



The research and educational departments of the hospital are located on the second floor. The laboratories were designed so that they can be rearranged to meet changing needs as the demands for facilities increase.

physiology. The laboratories are arranged for flexibility and can be easily adapted to changing needs. They are equipped to handle the routine work of the hospital as well as research.

The general arrangement of the third to tenth floors, inclusive, is similar for each floor. The service sections have been developed as a unit in the central part of the northerly side, permitting the use of the east, south and west sides for patients' rooms. The service section is considered a fixed unit as it contains the stairs and elevators, serving pantries, utility rooms, toilets, baths and treatment rooms. The remainder of each floor, however, was designed to provide the widest latitude for alterations in accordance with changing procedures in the care and treatment of cancer patients.

The third floor provides 25 beds for adults and 16 beds for children in a separate section at the westerly end. Special features of the children's section include several divisions to permit accommodations for children of varying ages and sex; complete cubicle equipment for each bed; self-contained units for utilities; babies' bath; isolation unit; nurses' station, and a separate roof for recreation. This floor also varies from the typical floors in that it provides access for all ward patients to the roof areas of the second story.

The fourth and fifth floors contain 39 beds each for ward patients in eight, four, two and one bed units, providing possibilities for progressive care and classification of patients. It should be noted that in-patients are classified in accordance with the clinical services previously mentioned and adequate treatment facilities are provided on all floors for each type of patient. The sixth to eighth floors contain 29 beds for semiprivate patients in three, two and one bed units. The private patients occupy the ninth and tenth floors with accommodations for 18 rooms on each floor.

The total capacity, therefore, is 242 patients. At present the fifth and sixth floors are used for the temporary housing of nurses and employes, which reduces the beds available to 174.

The eleventh floor provides an apartment for the superintendent as well as 16 rooms for resident physicians.

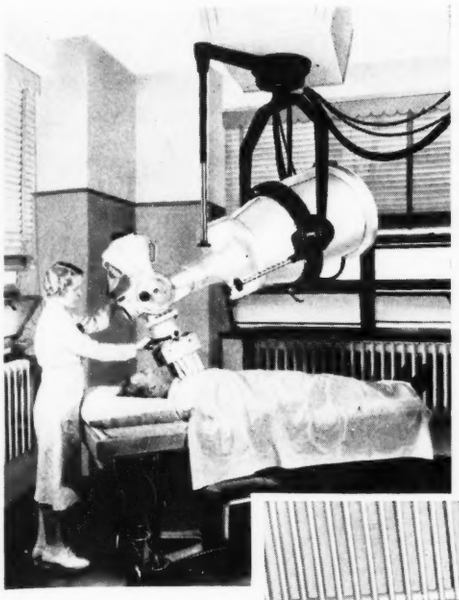
The operating suite is a self-contained unit occupying the entire twelfth floor with complete facilities for four operating rooms (two with provisions for spectators), plaster room, sterilizing and workrooms and staff dressing rooms.

The penthouse affords access to glass enclosed and open promenades for private patients and staff; service rooms, and a squash court.

Probably the most unusual feature of Memorial Hospital is the x-ray department with its associated services.

This department occupies an entire wing extending 280 feet along East Sixty-Seventh Street. It contains eight treatment rooms for general patients and four for private patients. These rooms are arranged in pairs with central control for each, together with dressing facilities and waiting rooms. The treatment rooms are completely lined with lead to protect persons in adjoining rooms.

Left: The attractive nurses' dining room, located on the ground floor, looks out onto a garden court. Below: A glass enclosed promenade for the use of private patients and members of staff.

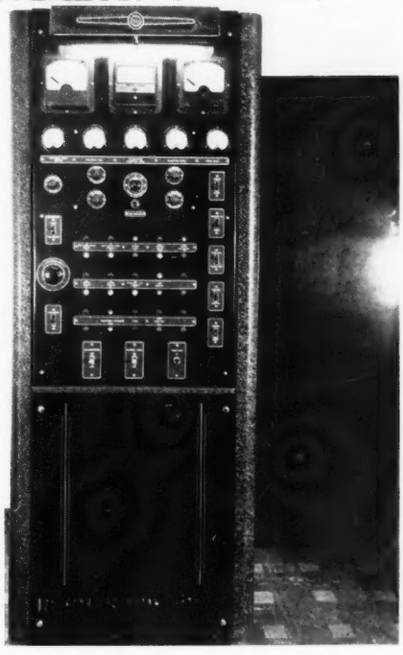


no radical departures from generally accepted hospital construction but they represent conservative and economical selections of design and materials. Finishes vary in accordance with the functional aspects of the sections to which they are applied; throughout the building they create a cheerful atmosphere and a sense of cleanliness and efficiency, essential in the proper handling of patients afflicted with this disease.

The special wiring required for the x-ray department was developed through consultation with the electrical engineer, the physicist of the hospital and an x-ray manufacturer. The adopted system is simple, direct and safe. Transformers for the x-ray therapy rooms on the first floor are located directly above in the second story and all repairs are made without interference with the patients or operators.

Above: One of five 250 kv. shockproof x-ray therapy units that are used for treatment at the hospital. Right: Transformer and accessory equipment for the million volt x-ray unit.

Above: The target end of the million volt shockproof unit. The technician is directing the x-ray beam to the treatment area. Bottom: Operator's control panel for the larger unit.



An additional room, centrally located in this section, contains the million volt x-ray machine, which projects into the second story. The entire space for this apparatus is insulated by concrete walls, 24 inches thick. Adjoining this room is the radium element pack room which is enclosed by 18 inch concrete walls. Special facilities are also provided for x-ray research in the physics laboratories and for radium emanations in the clinics and radon preparation in the basement. All such facilities must be properly insulated and planned with regard for their possible effect on other functions, for proper ventilation and for the protection of the staff.

The structural and mechanical specifications for this building make

Air conditioning has been used sparingly and the ventilation system in general is simplified to the extent of providing ample exhaust to ensure removal of foul air but it relies upon windows and doors for furnishing air supply in most instances. The operating rooms and x-ray sections are air conditioned by individual units, which makes it possible to vary conditions as required and also reduces the size of the units and the extent of the duct work.

Does All Cash Get Into the Till?

T. J. HUNSTON

THE old adage that "most people are honest" has been proved on countless occasions. Unfortunately, however, it seems that we shall always have among us a few individuals who insist upon acquiring for their personal use property to which they have no legal title. If the institution is to operate efficiently, it must place sufficient protective restrictions on the receipt, use and disposal of its property.

Of the numerous types of property in the modern hospital, the one that is likely to present the greatest problem is "cash," particularly the cash that is paid to the hospital for services to patients. Since it loses its identity when passed from one individual to another, there may be little that can be done in the way of recovery once it has fallen into the wrong hands. Hence, all of the channels through which cash, as well as bank checks, flows must be definitely defined.

Generally speaking, cash reaches the hospital through two avenues: (1) from individuals, and (2) through the mail. Cash received from individuals presents no great problem because few people pay bills without obtaining a receipt, but cash that is received through the mail, unless it is carefully protected, can easily be misdirected and never reach the hospital cash drawer.

A good accounts receivable control will reflect any discrepancies between the amount of money paid the hospital by patients and the amount of money credited to the patients' accounts. However, if there have been any irregularities prior to entry in the books this method may not reflect the discrepancies until considerable damage has been caused.

Because of this, several hospitals have adopted a policy similar to the one described in the following paragraphs in an attempt to eliminate any possibility of difficulties arising on this score.

Mr. Hunston is chief accountant, City Hospital, Cleveland.

Table 1—Flow of Cash into Hospital

Payment in Person	Payment by Mail
Patient to Cashier to Cash Register	Patient to Administrator's Office to Mail Register to Cashier to Cash Register

The best guarantee that all the cash received by the cashier from patients or their agents has been properly accounted for is the fact that most people who pay bills request written receipts. However, it remains for the hospital to furnish the cashier with either prenumbered receipts, all of which must be accounted for, or a cash register that automatically prints a receipt that can be given the customer. Either procedure provides as nearly complete control as is possible.

Every effort should be put forth to educate patients to pay bills by check or by money order. This is particularly important when payment is made by mail. Also, as far as is possible, each patient should be instructed to make checks or money orders payable to the hospital rather than to an individual officer or employe. This tends to centralize mail deliveries in one office, which in most hospitals will be the administrator's office.

The clerk who is assigned to open the mail is required to list each receipt of cash in an inexpensive bound register with columns similar to those in table 2, leaving columns 3, 6 and 7 blank.

When all the entries have been made for the day, the register and cash are turned over to the cashier, who writes a receipt for each entry, fills in columns 3, 6 and 7 and returns the register to the mail clerk for the next day's mail. It is particularly important for the clerk who records the mail in the register to check each day after it has been returned by the cashier to make certain that all of the entries have been properly made. If a cash register is used the number of the receipt and the cash register number should correspond. The final step is a daily check by the business office. The office copies of the receipts must check with the cash register tapes and cash deposits.

Table 2—Ledger for Entering Cash Receipts

Date Received	By Whom Paid	Account Paid	Amount Paid	Cash, Check Money Order	Receipt and Register No.	Cashier's Signature

The adoption of such a procedure provides the hospital with a chronological record of the flow of cash from the time it reaches the hospital until it is deposited in the bank. The responsibility for all cash has been placed in the hands of two individuals who can definitely be held accountable for all errors. It is well for the hospital administrator to remember that in many cases of "misappropriation of funds" there is a direct relationship between the act itself and the ease with which it can be accomplished. If the barriers are not sufficiently high to discourage the attempt even honest individuals may occasionally be tempted. Therefore, it is vitally important that each administrator establish and follow within his hospital a complete and rigid procedure for the control of all of its property and particularly the control of cash.

Problems in Employment

A Solution for Small Hospitals

MILDRED F. WALKER

FUNDAMENTAL principles of organization and management apply in equal measure to the small and to the large hospital, but the special aspects of the small hospital and its situation need to be recognized in dealing with matters of personnel.

The smaller community itself affects the basic questions involved, namely, what type of service is expected; what use will be made of the hospital, and where shall personnel be found?

To determine the number of employes needed to give adequate care necessitates a definition of the standards as well as the kinds of service to be rendered; an evaluation of the care required, and a thorough study of the amount of work to be done. A plan of organization must be prepared setting forth an analysis of the tasks involved and the job qualifications for each post.

Where and how to find those who by training, personality and general fitness are qualified to perform the various tasks is a perplexing problem. The small community prefers that its own members be given opportunities yet itself affords little scope for the selection of trained people. It offers little attraction to well-prepared persons from outside and the choice of those who are willing to consider the small hospital post is limited. Thus, the job must be made attractive from the standpoints of salary, living conditions and the work itself.

Efforts to obtain from teaching centers nurses to fill supervisory posts and anesthetists, technicians and dietitians often meet with little success. It becomes clear that the small hospital must turn toward developing its own personnel. After the candidates have been carefully selected, the administration should assist its own members to obtain special or graduate training.

The problem of training personnel is not an easy one for the small hospital to solve inasmuch as any program can be carried out only under the careful supervision of qualified persons and time must be allowed for the process of teaching these workers.

When services, such as x-ray and laboratory, are under the direction of qualified physicians, it has been found practicable to undertake the training of technicians when those of sufficient educational background and fitness are among the hospital's personnel or are present in the community.

Importance of Teaching

The institution that desires to improve its status must recognize the importance of teaching. Everyone who is entrusted with responsibility, including the superintendent and the heads of services, should have both the desire and the ability to teach. The department heads must be able to plan programs for their teaching, know how the task should be done, be able to demonstrate the method, give clear directions and prepare definite schedules for each worker.

A program of instruction for the new employe must be carefully thought out. Behind this lie the job analysis and the detailed enumeration of the elements involved in each task.

Schedules of the order and time of performing duties aid in developing routine and integrate the work of each employe to the whole. Written orders need to be compiled for every job. Clear directions are essential to develop well-trained workers. When assembled, these become the handbook of procedures for the institution. Training personnel does cost money but it saves money in the long run by producing better and more quickly executed work; moreover, it gives greater satisfaction to the worker and enhances the hospital's reputation for quality service.

The effort expended in finding and training personnel must be bulwarked by policies and conditions that will offer continued attraction to workers who become efficient. The satisfaction an individual seeks in the job is the element to be fulfilled if employes are to be retained.

Persons who are too capable for the work for which they are engaged grow restless and those of insufficient capacity become victims of nagging supervision. Special attention to the selection and placement of the worker is required. This is not easy when pressure makes necessary the employment of the only individual available. However, a plan for personnel management that is well thought through and is altered as experience indicates is the goal to be sought.

An employment plan that provides promotions reduces restlessness and offers a goal for attainment and a reward for achievement. A graduated salary scale within the various classifications of personnel attracts abler applicants. It is possible to employ more capable personnel in the lower salaried positions if there is opportunity for working up. Even in the small hospital some provision for graduation in jobs is possible. Where the ambition and fitness of an individual justify it, posts in the favored categories should be filled by promotion of workers from within.

When room and board are included in the compensation, living conditions should afford an atmosphere comparable to home life. Happier relationships and longer periods

Miss Walker is superintendent of Detwiler Memorial Hospital, Wauseon, Ohio. The article is condensed from a paper presented at the Tri-State Hospital Association, Chicago, May 1940.

of service could be obtained if fewer employes were required to live in dormitories.

The atmosphere of an institution has great bearing on the morale of workers. It is created by those in authority. The relationship that exists between the administration and the heads of services is reflected throughout. Loyalty and respect are shown by employes in direct proportion to their existence among those in charge.

A dissatisfied worker not only disturbs but harms the organization in the community by the attitude he carries forth. There is no place for the malcontent in any group of a hospital where willing and eager service is essential for the welfare of the sick.

Grievances must be met before they have time to grow. They should be "aired" within the institution and easy access to the head of a service or even the superintendent is the surest way of minimizing an irritation. Allowed to develop without a hearing, an irritation increases out of proportion to its importance and the morale of the entire staff may be undermined.

The health of an employe must be guarded. Through physical examination the hospital must make certain the employe is in good health when he joins the staff. Thereafter, the hospital owes to its employes the same concern for their welfare as for the patients it serves. Physical examinations at yearly intervals are imperative and chest x-rays should be made when necessary.

Decent working hours are paramount. In most cases eight hours a day with one full day off each week should be the maximum. Whatever is required for additional salaries is saved by fewer absences, sick leaves and resignations.

Sick leave with pay is as much due the ward maid, the nurse or other employe as the superintendent. Whatever the policy, it should be one of fairness to all. Sick leave for nurses facilitates sending them off duty at the first appearance of a cold, preventing more serious illnesses with consequent longer absences from work. When leave is not granted, there is reluctance to take time off if wages cease.

Vacations should be included for all workers, with a definite period established for each group as a part of the general regulations of the hospital.

Praise for work well done buoys the spirits of everyone. Appreciation of personal problems affecting an employe does much toward making him feel he is of importance and earns his devotion to the job and the institution.

Let employes know more about the business of the hospital. Knowledge begets u n d e r s t a n d i n g. A planned method of education should be instituted by the administration to change employes from knockers to eager interpreters as they move in the community.

Conferences, individual and group, and informal social gatherings, such as parties and picnics, are means for closer contact between the administration and the various workers.

Charts and bulletins can be used to advantage to obtain cooperation in effecting economies. Most employes think of their institution as making money and have no realization of the costs involved in its operation. Little wonder that cooperation is difficult to gain. The thinking of the average worker follows that of the community. Without knowledge he may become a gossip monger; fortified with information he turns to explanations and serves as an inexpensive means of good advertising.

Employes require only what we ourselves desire—a job that pleases them; fair opportunity; a right to a respectable standard of living; reasonableness on the part of those who direct, and a chance to feel that their tasks are important contributions to the care of the sick and that they themselves are a necessary part of the institution that they serve.

Religion in the Hospital

ELIZABETH MILLER

THERE is an especial need in hospitals for the consideration of the religious beliefs and desires of the patient.

Circumstances beyond the patient's control have suddenly placed him in a position in which he is more or less dependent upon strangers for his bodily and physical comfort and to know that he has only to express his desire for a visit from his own pastor or clergyman may be a source of great mental and spiritual comfort to him.

As the Paul Kimball Hospital, Lakewood, N. J., is nonsectarian we sincerely welcome the clergymen and representatives of all religious beliefs. And they are admitted at all hours of the day and night.

Since we serve patients from an area within a 45 mile radius our admitting department cooperates in every way possible by sending postal cards or telephoning to the ministers of the churches with which the patients are affiliated.

Miss Miller is superintendent of Paul Kimball Hospital, Lakewood, N. J.

All food is served from a central kitchen. If anyone wishes a special service to conform with his religious belief his family is allowed to send in the food half an hour before the regular time for serving the meal. This food is sent to the diet kitchen so that it can be inspected by the nurse in charge to see that it conforms to the diet ordered by the attending physician. This plan works well and thus far has resulted in no friction.

Our ward beds are equipped with cubicle curtains, which ensure privacy. Catholic patients' requests for a priest are granted at all times and a communion service is available for the priest's use.

We allow a room adjacent to our accident room in the basement to be used for the ceremony of circumcision. Near by is the waiting room for the physiotherapy department, which serves as an assembling place for the guests and thus noise and confusion are confined to one part of the hospital. There is no charge for any of these services.

The Head Nurse as a Teacher

ELIZABETH ROMINE, R.N.

THE position of head nurse has been called the key point around which the administrative mechanism of the hospital is built. It is a well-known fact in nursing circles that many women who have occupied this position in the course of their careers and then have gone on to supervision, teaching or administration have been unable to find so great a satisfaction in any of these other forms of service.

What is it that makes head nursing such satisfying, thrilling work? Probably most head nurses would reply to such a question that they have intimate contacts with both patients and staff members, and that they enjoy meeting and solving the problems that executive work involves.

There is another reason implied by this statement about "intimate contacts with people," however. In no other position does a nurse have such opportunities for teaching. The head nurse should be an expert in her special field of nursing, qualified by preparation and experience to teach those with whom she comes in contact.

These individuals can be divided into two groups: the personnel, which has a definite part in the mechanical functioning of the ward or unit for which the head nurse is responsible, and the patients. The first group includes the nursing staff, which has the most intimate contact with patients. The head nurse may be in a teaching institution that includes student nurses in its group of learners. If so, she has a definite part in the curriculum and assumes her teaching responsibilities as a member of the nursing school faculty. She is concerned primarily with teaching skills, attitudes and factual details of the principles that students learn in the classroom. Every assignment planned for student nurses, no matter what the phase of ward duties, should be planned with a dual purpose: first, teaching; second, service. If the teaching purpose is not paramount, then the school must look carefully toward the aims of its curriculum in order to justify its existence.

Hospitals in which the head nurse has an entire graduate staff are now increasing as hospital administrators are realizing the greater efficiency and long-time economy of this kind of patient service. However, an all graduate staff does not mean that perfect service has been attained, thereby eliminating the teaching responsibilities of the head nurse. The head nurse is still an expert and should know more than her staff if she is to guide it wisely. With a graduate staff it is her task to integrate the skills, technics, attitudes and knowledge of those who come to her into a wholesome personnel relationship which, at its best, works with marvelous efficiency.

Second in the personnel category are employes who are variously designated as ward helpers, attendants, maids, housekeepers, orderlies and understaff, with as many varied duties and responsibilities as there are people to define them. Their importance in hospitals is becoming increasingly apparent to executives who recognize the advances in professional nursing. Most institutions employ such individuals and train them on the job; here again it is the head nurse who must assume the responsibilities of teaching.

These employes are assigned largely to unskilled and housekeeping duties but these duties often bring them into contact with dangerously infectious materials. It is essential, therefore, that they know the facts of disease transmission and medical asepsis, so that the complex technics involved in preventing the spread of infection will not be ignored or violated. In some instances, these employes will have more or less direct contact with patients, and so will need instruction and guidance in the ethical principles that must govern the conduct of those who minister to the sick.

The head nurse is absolutely responsible for the work of both groups—for the duties they perform;

Lawrence General Hospital, Lawrence, Mass.

Student nurses compose one of the most important groups of learners.

Miss Romine is instructor in the school of nursing, Children's Hospital, Boston.

Manchester Memorial Hospital, Manchester, Conn.

The head nurse has a definite responsibility for teaching the patients.

for methods of performance; for accuracy, neatness and finish; for volume of work or speed, and for the integration of the individual efforts into perfectly blended patient service. Thus, it is easy to understand why she must be not only executive but teacher as well.

There are others of the hospital staff who are closely connected with the smoothness of ward administration. To these individuals the head nurse has teaching responsibilities which, if left unrecognized or neglected, will prevent the highest attainments of staff cooperation. First in this group is the resident medical staff. Many physicians remember with gratitude the practical hints and fine clinical details that they learned as young interns from wise head nurses who knew how to make these points apparent without overstepping the bounds of professional etiquette.

Medical students in teaching institutions have learned much of the nursing skills that are necessary to a complete understanding of the treatments they administer from the nursing staff. Some schools have now progressed to the point of including instruction in nursing in the medical curriculum. Without this teaching on the part of nurses, many of the newer procedures that have made treatments safe and effective for patients might still be untried and unknown.

Still others included in this group are dietitians, social workers, psychologists, technicians and clerks, without whose complete understanding of nursing, its ideals for service and its problems, desirable cooperative interaction is impossible. This teaching is usually personal and informal. It is not always clearly designated as teaching by the head nurse herself or by those whom she teaches, but surely teaching takes place wherever there is an exchange of ideas.

Up to this point our discussion has concerned only those who have to do with the mechanics of making a hospital ward function. We have not yet considered the main object in this set-up, *i.e.* the patient who is the sole reason for the existence of the hospital. The patient is the object not only of our care but also of our instruction. The head nurse is responsible for making his stay in the institution as pleasant and profitable to him as possible.

It is a rare individual, even if a member of the medical or nursing profession, who can spend any appreciable time in a hospital as a patient and not learn something that he did not know before. Here he gains in new experience, unfortunately much of it unpleasant, and he learns new facts about disease and sickness simply by being exposed to them. In addition he should learn, either directly from the head nurse or through those whom she "teaches to teach" him, what conditions may have predisposed him to his illness, what he must do to get completely well and, most important of all, how he must live to stay that way.

Probably more than any other member of the hospital staff the head nurse will come in contact with the patient's visitors. She can help friends and relatives to help the patient and, perhaps, even to improve the state of their own health.

In no field of nursing is the teaching opportunity greater than in pediatrics, for here the nurse can teach her young and impressionable patient facts about himself and his disease, how to build good hygienic habits and how to acquire a healthy attitude toward health. To his parents or to those responsible for him, she should teach the essentials of good physical care and principles of management and guidance.

Health teaching in its broadest implications is being emphasized in modern nursing education as never before. If our highest objectives are to be attained, the head nurse must be an expert in teaching as well as in nursing.

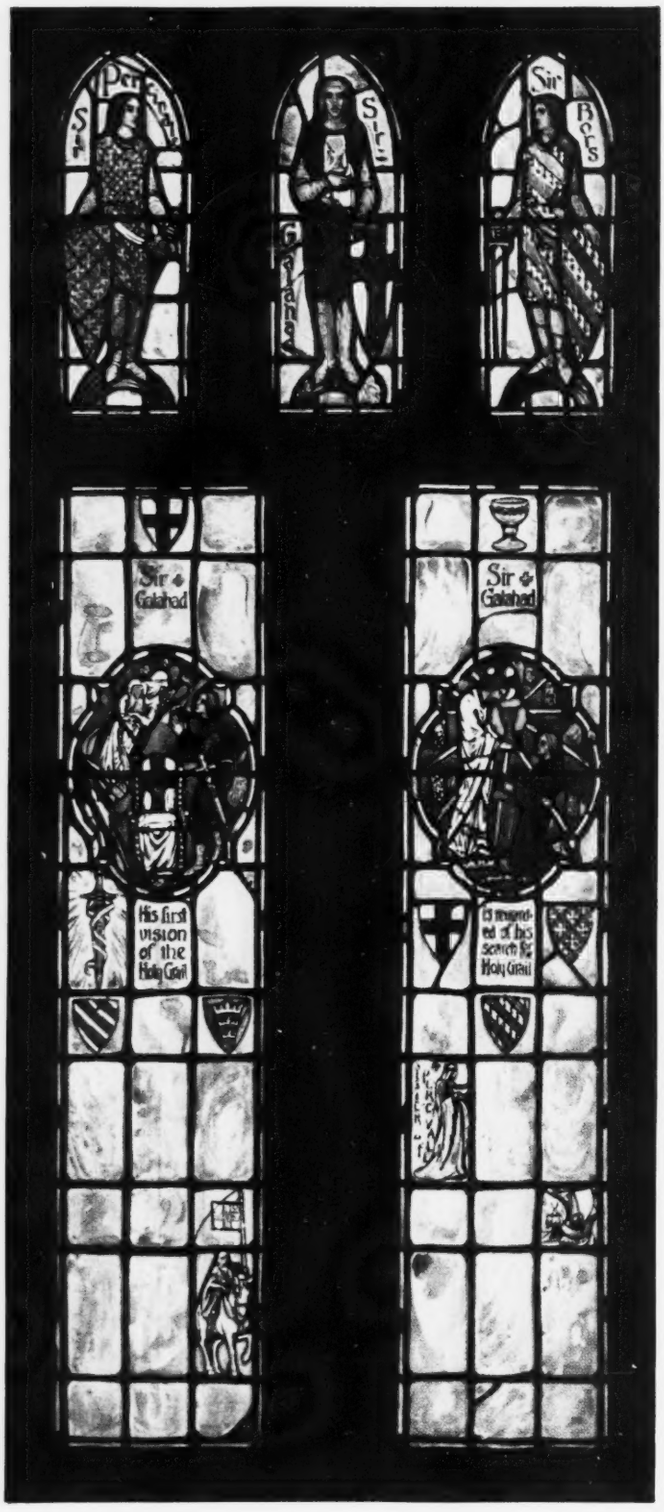
Break the Vicious Circle

Chronic disease is one of the most frequent causes of poverty and poverty is a contributing cause of chronic disease. The patient is most often released from this vicious circle by death, after a long period of suffering in which more than one person is involved. However, in many instances, there is another way out for an enlightened community.

Scientific interest in the chronically ill is purchasable within reasonable limits. This problem belongs, therefore, in the field of social security. The philanthropist can make another great contribution here by going into partnership with government to break this vicious circle.—E. M. Bluestone, M.D., *administrator, Montefiore Hospital, New York.*

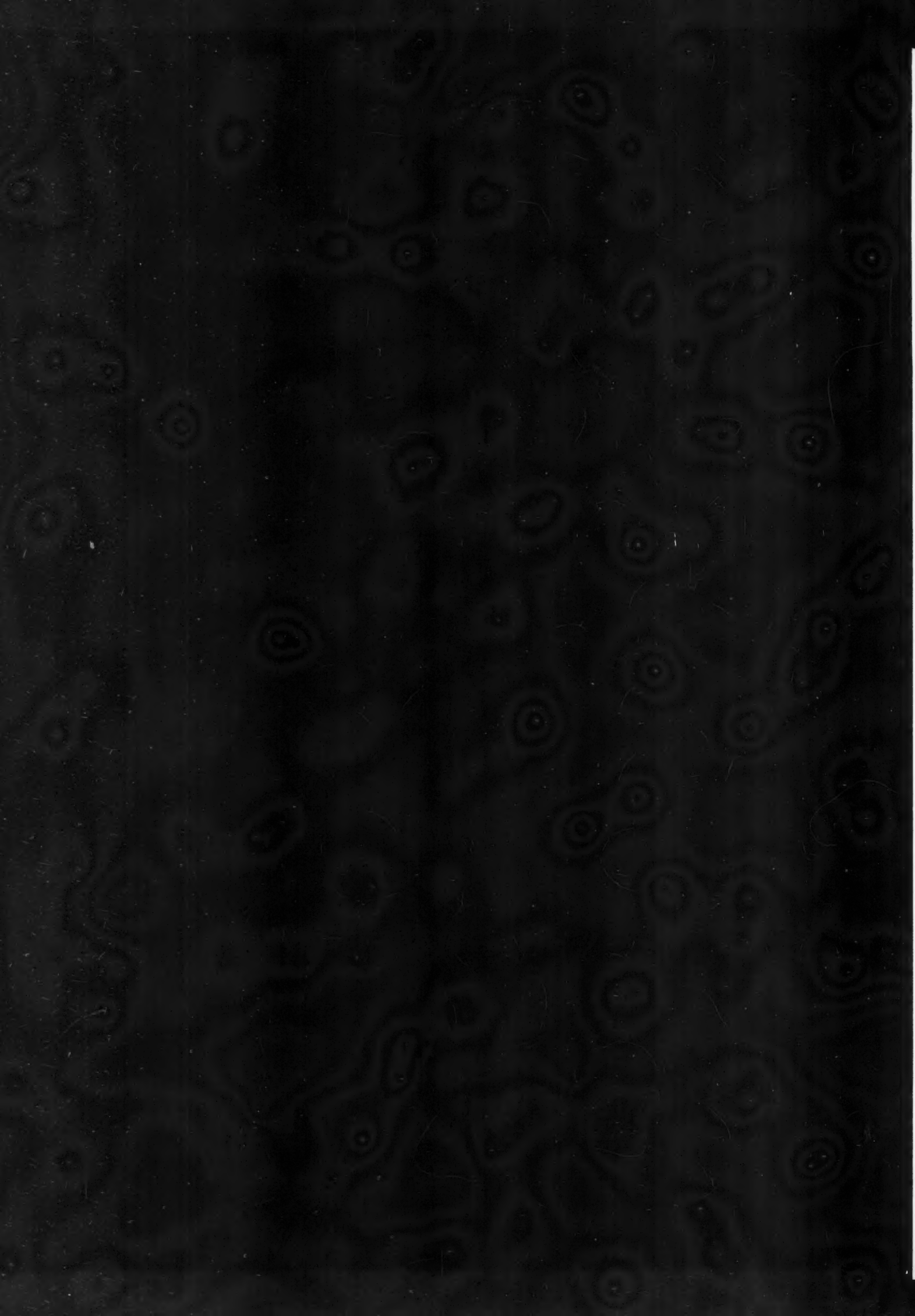
Mapping Your Week in Boston

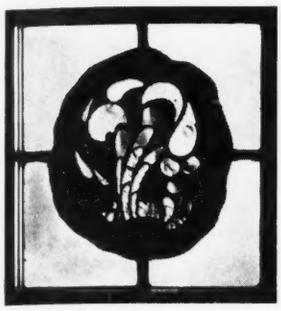
September 13 to 20



SIR GALAHAD WINDOW

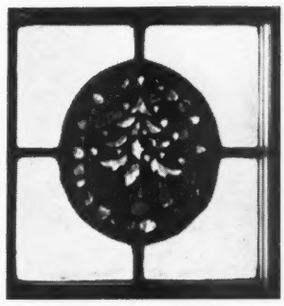
In the Rest Room, Children's Hospital, Cincinnati





THE FOUNTAIN

Stained Glass Windows



CHRISTMAS TREE

CHARLES J. CONNICK

ONE of the pleasantest memories that crowd the mental record of a happy life hovers about a well-known children's hospital. The idea of making a children's rest room and an adjoining chapel radiant with the light and color of stained glass came to me in gracious fashion. A gentlewoman appeared in my workshop one morning with her son, the architect of the hospital then under construction. She believes that children's minds and hearts are always receptive and thought that possibly every room in the building should have its glowing spot of color and light.

Not everything can be done at once; however, youngsters convalescing and at rest after trying experiences are pretty sure to have their little perceptive doors and windows thrown more widely open than ever before. Then, why not make that rest room and the chapel opening from it glowing reminders of the beauty that lurks everywhere? Why not have windows that would let in plenty of light through areas of transparent and translucent glass, enriched by medallions and small figures in full color?

It seemed freshly significant to me that the chapel and rest room of Children's Hospital, Cincinnati, Ohio, were separated only by folding doors. It was decided to have the four windows set forth four youthful archangels with their distinctive pure colors and symbols. So Saint Gabriel, Saint Michael, Saint Uriel and Saint Raphael, who served as guardians of growing children, are placed in the immediate vicinity of a series of medallion windows devoted to the founder of Christianity. Near by, a host of witnesses include saintly characters, fairy kingdoms, Sir Galahad and his brother knights, and rough-hewn worldly folk like Huckleberry Finn and the strange assortment of human beings that Treasure Island makes immortal.

If the good people on the committees shuddered at the idea of pirates, divine histories and archangels in close proximity, I can only remind them that all those windows were the gift of a grandmother and her architect son who were blessed with imagination and who set an artist free to be himself as a creative child in his own resplendent world.

Can artists always be trusted to enter hospitals, libraries, schools and churches without the guiding hand of committees and architects? I have written a big book to answer that and other equally pertinent questions about the craft that nobody knows. It is called "Adventures in Light and Color" and is a gay picture book for big and little children, a book that has found its way into many hospitals.

That question about freedom for glassmen reared upon me recently when I visited a suburban hospital where I have become acquainted with the serene spirit and the friendly competence that should characterize all hospitals everywhere. It is in a lovely countryside where thrushes join less timid songsters in morning serenades and where trees and flowering shrubs of all sorts make every inch of the country round about attractive and healthy to all eyes.

Buildings are surrounded by space so that they get a beautiful free light. This I noticed at once, because I am by way of being in partnership with Brother Sun and, therefore, a natural lover of light.

As I entered the children's room, I received an impression of strangely subdued light. The children welcomed the stranger with smiles, wide eyes and even with timid greetings. Perhaps the greetings were somewhat reserved because my face must have taken on an expression of chagrin and violent dislike; for that room, with all its sensitive little occupants, was dominated by a huge depressing window belonging to the art glass industry of the late Nineties.

As I noticed its blanketing of the light, I sensed at once a paradoxical situation that is familiar to me in problems related to church enrichment but that I had never seen so clearly announced in a hospital. The window should have recorded a generous impulse actuated by loving thoughts like those of the gentle grandmother at Children's Hospital, Cincinnati, but those thoughts never reached the window makers.

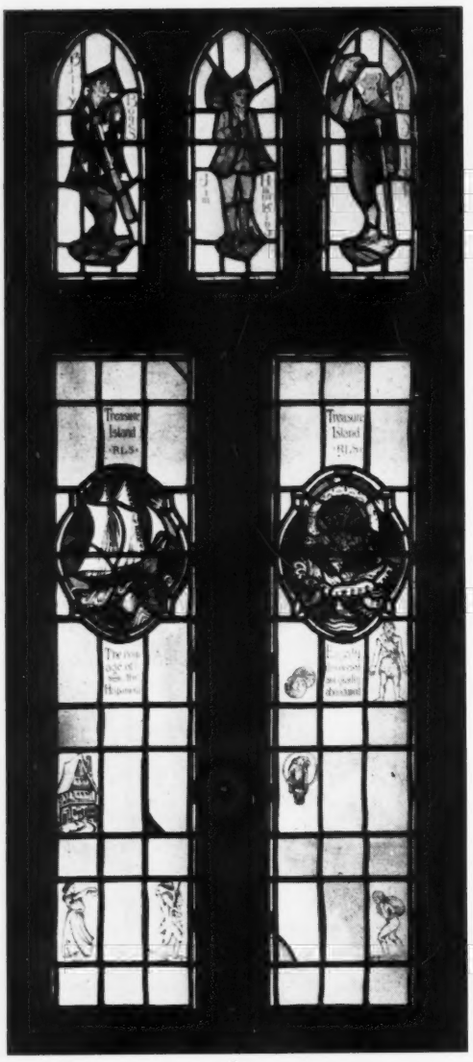
The window is a memorial to a child, whose stiff little figure was evidently reproduced from a hand-colored photograph in an art glass factory where men registered on time clocks and worked under their realistic shadow without a thought for Brother Sun and his radiance.

My violent condemnation of these hired men who, without convictions or enthusiasm, had perpetrated that dull monstrosity was followed by a lively impulse to make a gesture to

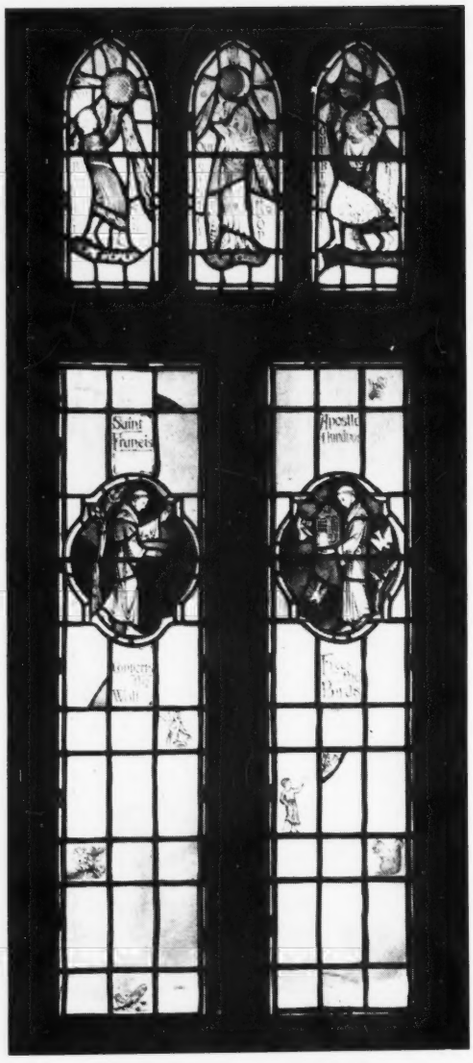
AN INVITATION FOR YOU

Convention-goers are invited to visit Mr. Connick's workshop on Wednesday, Thursday or Friday, September 18 to 20, from the hours of 10 a.m. to 4 p.m. To be seen there will be examples of the work that is to enrich the windows of the new chapel at the Massachusetts General Hospital

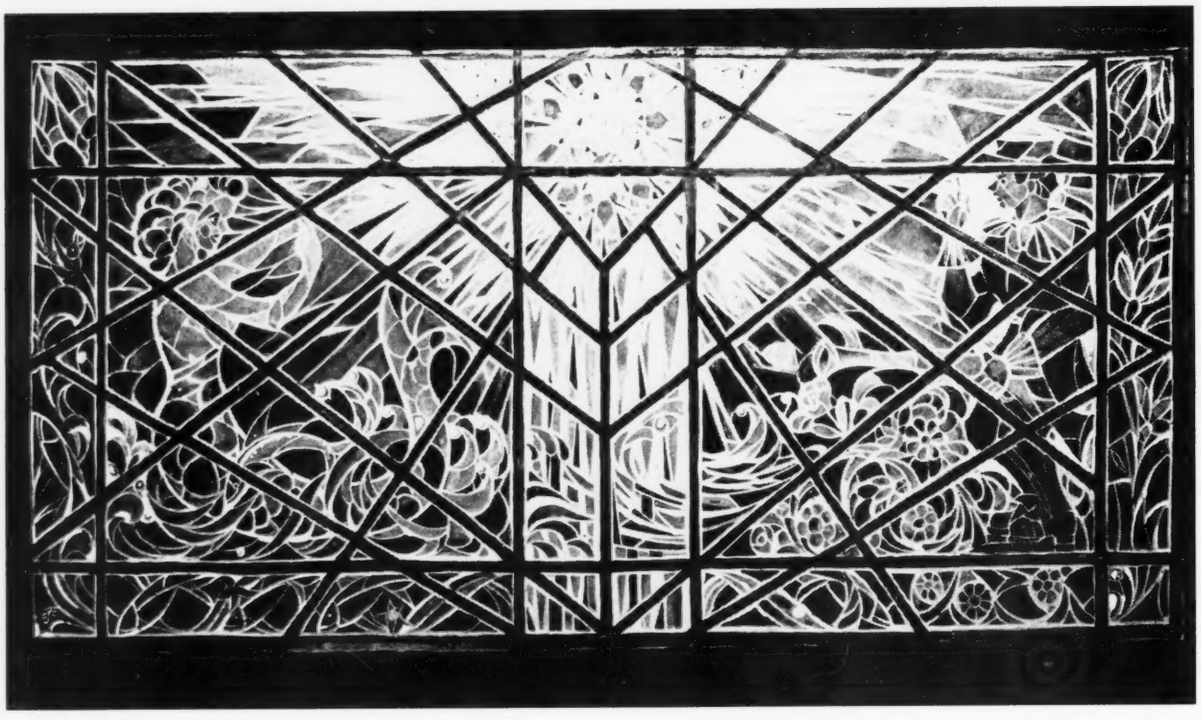
Mr. Connick is a master craftsman in the design of stained and leaded glass.



TREASURE ISLAND WINDOW



ST. FRANCIS WINDOW



"Coloralight" mosaic suitable for hospital use. It is now on display in the Contemporary American Industrial Art Exhibition at the Metropolitan Museum, New York. It is designed by Connick for artificial light.

Brother Sun in some near-by transom lights as an apology for my art-glass stepcousins.

When official permission was given me, I set forth glowing little medallions in prismatic pure color. One is a Christmas tree, the other is a fountain, and I am gratified to know that Brother Sun has returned to that children's room.

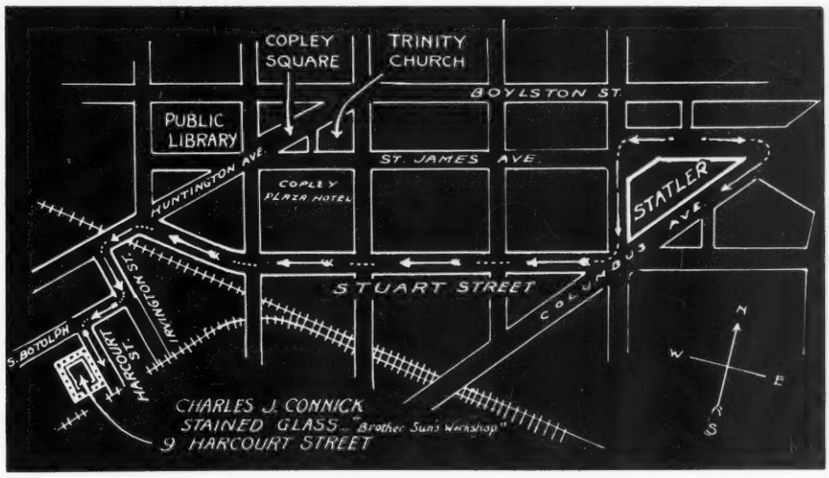
I have entered a hospital as a patient only once and, because it was for an examination only, my stay was a particularly pleasant one. I was so impressed with the good will and good sense of the entire staff that I sent, as a long-time loan, some of my precious Sandwich glass medallions "to hang in windows where flowers are not too plentiful."

Hearty responses were still tingling on telephone wires when a horrified voice announced that a medallion had been stolen. Since such gorgeous things were evidently not safe among ordinary human beings the hospital returned the rest of them to me promptly.

It is an interesting coincidence that the good Bishop's Chapel on the windows of which I am at work is designed for that same hospital. Shall I not take renewed delight in a collaboration there with Brother Sun, in glass so rugged and so varied in texture and pure color as clearly to resemble the Sandwich glass of the lost medallion, its power to drag daylight down past lowering walls and its lyrical messages to suggest

"—what rainbows teach
And sunsets show."

Now that artists and poets have been joined by psychologists and physicians, isn't it fascinating to discover that our brothers of the Middle Ages anticipated all of us by as many as eight or nine centuries?



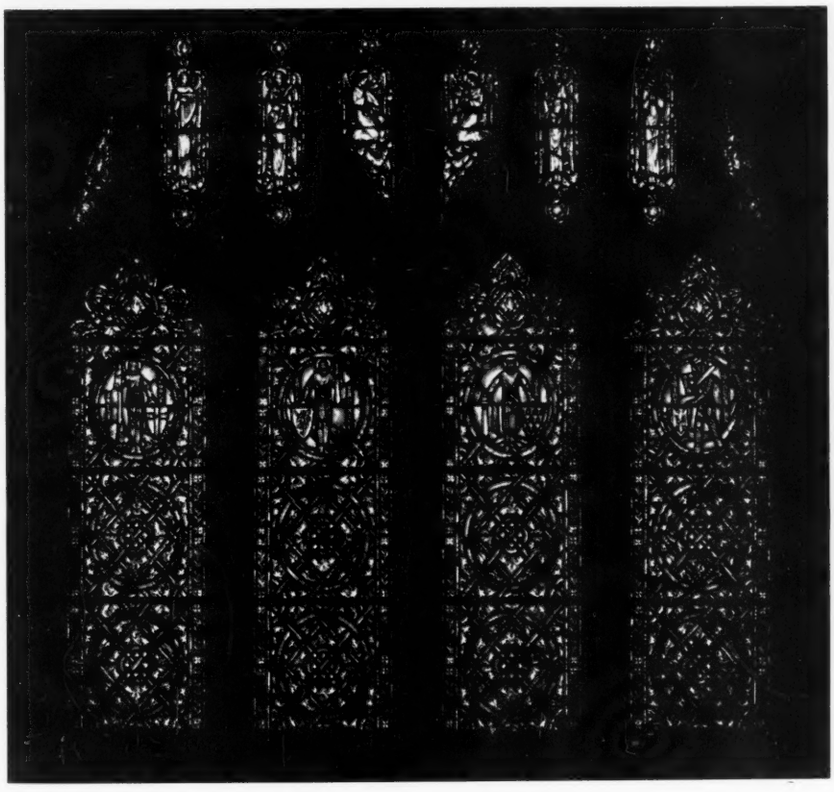
The way to Mr. Connick's workshop from the Hotel Statler. A.H.A. delegates are invited to visit it on Wednesday, Thursday or Friday.

When we hear the intellectual pronouncement that the cool area of the spectrum restores frazzled nerves and quiets fiery imaginings, we are agreeing with ancient glassmen and with colorists like Dante. Dante said that blue is the contemplative color, the color of divine wisdom, of loyalty and eternity; blue-violet, the color of justice and mercy; green, the color of hope, youth, victory and good humor, and white, the symbol of faith, serenity and peace.

When modern authorities tell us that red is the vigorous stimulating color, which, with red-violet, orange and gold, may increase the power of tingling nerves while stirring lethargic minds to healthy vigor, they also have Dante's medieval symbolism of color as a background. For red is the color of divine love, the greatest creative force that Dante knew. Red and red-orange also implied courage, martyrdom and passionate devotion, while gold, or pure yellow, urged the doing of good works and the gathering of heavenly treasures.

But neither in the olden times nor today can the vibrant rays of color-in-light be adequately presented in listed qualities and their implications. The art of recalling the thrill of rainbows and sunsets cannot be set forth by rule and line.

It will bring me pleasure if all lovers of color shall sometime see, even in humoresques like my Doc Higgins-Mermaid panel, designed for a modern artificial light, a gay little lyric to lighten dark spots and darkened minds in regions devoted to healthier and happier human beings.



Morning chapel chancel window at the Army Medical Center, Walter Reed General Hospital, Washington, D. C. It is grisaille with symbols and represents militant saints, St. George, St. Louis (king), St. Maurice and St. Wenceslaus. All the windows shown are by Charles Connick.

RAYMOND P. SLOAN

Community Spirit

Photographs by M. K. Bovey Jr., Concord, Mass.

Above: The hospital was designed to conform to the low, rambling style of architecture that is found in New England. Right: A corner of the sun parlor overlooking the Sudbury River.

DURING months of good weather the streets of the old Massachusetts town of Concord are dotted with groups of visitors who travel great distances to absorb its historic atmosphere.

So busily engaged at one end of the town are most of the people who visit Concord that they are not likely to discover Emerson Hospital unless by chance their route leads in that direction. It lies to the southwest of the village past the old South Bridge over Sudbury River. A sign post explains explicitly—"Old Road to Nine Acres Corner." Even then, it is necessary to watch closely, for there is little to distinguish either the hospital or the nurses' residence from the attractive homes that dot the countryside.

The nurses' residence, in fact, has been serving in that capacity only a few years, having previously been a family home that was moved alongside the hospital and enlarged to fill its new rôle. The main building, while designed as a hospital, was made to conform to the type of architecture that is found through New England, *i.e.* frame construction with low, rambling wings. A community hospital should look like a community hospital, it was believed, and that is precisely what Emerson is—a community hospital.

Before explaining precisely how it serves as a community hospital, there are certain things we should know about it: that it has a bed capacity of 49, for example; that it was opened as a 14 bed general hospital in 1911 under the auspices of the New England Deaconess Association with a maternity department added the following year; that five years later an annex was added; that in 1924 the New England Deaconess Association deeded the property to the Corporation of the Emerson Hospital in Concord which renovated the plant and reopened it with a bed capacity of 22; that in the spring of 1927 the nurses' home was added, which released more rooms to patients and brought the bed capacity up to 49. As might be supposed, it is approved by the American College of Surgeons, and every one in the community it serves, comprising some 10 or 12 towns with a population of approximately 20,000, is as proud of it as can be.

The community's interest is enlisted through the Emerson Hospital Aid Society, an organization boasting some 1500 members, including men, women and children. Every one who gives anything to the hospital, no matter how small the gift, is enrolled. Many of these persons take part in committees that perform important functions. Others are kept from doing so only because of the difficulty in finding work enough to go around.

Let's see what some of these functions are. Topping the list is the contribution committee. There is one financial appeal each year, and only one. The hospital has a small endowment; therefore, support must come from the community to make up the inevitable deficits. This committee undertakes responsibility for the annual drive and does it successfully, judging from the figures that reveal a net return of approximately $8000 annually.

Then there is Donation Day for which there is a special committee. At a specified time each fall comes a

at Concord

varied assortment of gifts from all over the community. Anything is welcome but money. That must be saved for the annual drive. Special shelves in a cellar storeroom are provided by Edna D. Price, superintendent, and her associates for the avalanche of jellies, jams and preserves that flows in—sufficient to keep the kitchen abundantly supplied for many months. Similar arrangements are provided for other food stuffs and miscellaneous gifts for which some profitable use is always found.

Another committee assumes responsibility for hospital furnishings. Every room, it seems, is maintained by an organization or individual. This committee meets once a year in March when the superintendent goes over the building with its members and provides them with a list of what is needed. They are given until National Hospital Day to see that the list is completed. What more effective way of ensuring a well-kept house for inspection!

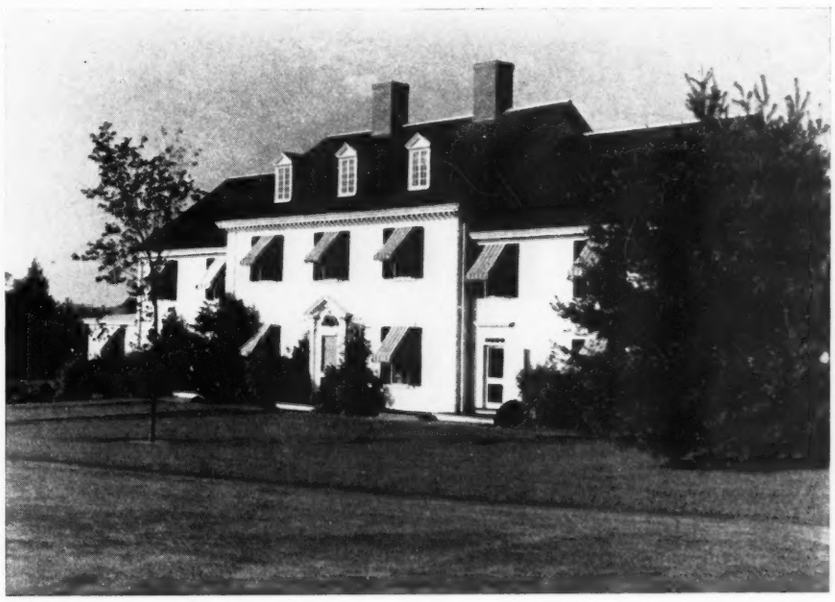
To make those who work within the hospital feel that they are part of the community, a committee provides entertainment for them during the year. Invitations are extended occasionally to the graduate nurses to have dinner in some home. There is always one party a year for the students—a sleigh ride, an evening at the movies or some other festivity. Once a year the president of the society may invite all the nursing staff to a picnic. It is possible that this is one of the reasons why, from a group of seven graduate nurses, five have been in the employ of the hospital eleven years or longer.

There is a publicity committee, of course, whose duty it is to get constructive information about the hospital into the local papers, particularly in connection with the Annual Appeal and Donation Day. Extremely helpful in maintaining interest is the bulletin that is issued three times a year to every society member. This may cover one subject or many.

So important is Christmas that a special committee is appointed to handle all arrangements. Its two members assist with the parties that are given for the nurses and patients and purchase candy and all the extras, including some little remembrance for every patient and a Christmas card or favor for each of the three Christmas trays.

All clerical work in connection with the society is handled by a committee whose members maintain the lists and file cards and mail the annual report and bulletins.

A flower committee works directly with the garden clubs in the various towns and sees that they appoint members to bring flowers to the hospital. Two flower arrangements a week for the front hall, as well as flowers for patients who have none, are requested. In winter, instead of flowers, the women furnish artistic bouquets of pine, fir and hemlock.



Above: The nurses at Emerson have a home that really looks like home. It was formerly a private residence and was moved near the hospital. Left: The living room in the nurses' residence.

The household nursing committee serves in a liaison capacity between the hospital and the Household Nursing Association with which it is affiliated. Another group assumes responsibility for special favors for the 15 holidays scattered throughout the year. No danger of patients in Emerson Hospital being neglected!

National Hospital Day receives the attention of certain women who furnish tea and other refreshments in the nurses' residence for every visitor.

One of the aid society committees handles a rummage sale that is held

the first Saturday of every May, the proceeds of which go to finance the society. This takes place in the state armory and nets from $700 to $1000. Out of this the society meets its own obligations and generally donates $300 or $400 to the hospital for special needs.

Then there is the linen committee, which, in reality, is a mending committee. The women of this committee also make binders and nursery bed linen.

A personnel of 1500 without and 35 within! The community of Concord and surrounding towns know the hospital people and their problems. The Emerson Hospital staff, on the other hand, recognizes the assistance that a well-conducted auxiliary can render and welcomes its interest and aid.

Mention has already been made of the seven graduate nurses, including Miss Price. The rest of the nursing personnel is composed of 18 students from the Household Nursing Association Training School for Attendant Nurses in Boston with which Emerson has an affiliation. In Concord this is regarded as the solution to the nursing problem in small hospitals.

Girls who register in the Boston school receive one and a half years of practical training, one year of which is spent in the hospital. The first two months of their hospital training constitutes a probationary period, following which they are capped student attendants.

What would happen if Clifton Fadiman of "Information Please" quizzed Miss Price about her practical nurses? Here is exactly how it would sound. Incidentally, this "quiz" formed one of the society's bulletins.

Mr. F: Do the attendant nurses take care of patients or do they just carry trays and keep the wards clean?

Miss P: They take all the routine care of patients.

Mr. F: Does this routine care of patients include all treatments?

Miss P: No. The more complicated treatments, such as drainage, dressings and irrigations, are done by the graduate nurse supervisors.

Mr. F: Are the patients satisfied with the care given them by the student attendants?

Miss P: Yes, they seem to be well satisfied. Our students are well taught by the superintendent of nurses and carefully supervised by the head nurses on the wards.

Mr. F: Do you find it less expensive to train students than to employ all graduates?

Miss P: Yes, we do; but it is not entirely a question of money. I am convinced that this plan answers many problems of a small hospital such as ours.

Mr. F: How long do the student attendants remain at the hospital?

Miss P: We have them for twelve months in the middle part of their course and they spend two months at the school in Boston learning to cook and to care for a house.

Mr. F: Why do they need domestic training?

Miss P: Because the association is preparing them to care for mildly ill people in their homes. They meet a real need in many households because they know how to cook as well as nurse.

Mr. F: Suppose I had the grippe and needed one of these trained attendants. How would I get hold of her?

Miss P: You could call the Registry of the Household Nursing Association, Kenmore 8410, or I should be glad to call for you and explain just what you need.

So much for the nursing situation at Emerson. Next comes an excursion around the plant, with Miss Price serving as guide and commentator. We are looking for ideas that are particularly adapted to small hospitals.

Color in the rooms! Don't look at the walls, but at the ceilings. After all, what does the average patient look at most of the time? Very well then, give him a soft shade on which he may rest his eyes rather than cold white that will only tire them. The walls are neutral but further color to harmonize with the ceiling is introduced in the window hangings.

When old mattresses are made over, what happens to the covering? Some may throw it away, but such is not the practice at Emerson. Covers are transformed into the most practical kind of laundry bags and bedpan covers.

In fact, this is only one small part of what is known as a "hand-me-down" system which saves more than anyone realizes. Linens and hangings are made over and over until there isn't anything more to work with. Curtains for tall windows are adapted for use at small windows. Fat used in cooking is made into soap for kitchen use as "extra" when emergency demands. The paper in which the linen is wrapped at the laundry is used to line bureau drawers and for closet shelves.

In the storeroom there is a substantial work table in the center where

The shelves in the storeroom are filled with neatly stacked items. The work table is made with drawers that can be pulled out either direction.

baskets for the different floors can be filled. The bench has drawers so arranged that they can be pulled out either way.

A rule requires that every one who breaks anything must put in with the requisition a piece of the article broken. Students are charged for breakage as it is deemed a part of their education to make them feel responsibility. Maids who are handling breakable items all the time are not charged unless they average seven pieces a week.

It is taken for granted that patients in the small hospital are visited regularly by the superintendent or her assistant. What better time is there for such a call than at dinner or supper when the patient is "finishing up"? This provides an opportunity to determine whether or not he has enjoyed his meal and whether anything else can be done to make him more comfortable.

The superintendent in the small hospital must do all sorts of odd jobs, filling in here and substituting there. There must be flexibility, in fact, throughout the entire organization with duties overlapping to meet any emergency.

At Emerson, for example, Miss Price at various times is dietitian, housekeeper, record clerk, purchasing agent and personnel manager. Her assistant is superintendent of nurses and more. She teaches, supervises the students on the floors, has charge of linen and is supervisor of the nurses' home.

The nurse anesthetist is also x-ray technician and has charge of a small surgical and medical ward. Two staff doctors cover the anesthesia service when she is off duty.

The operating room supervisor is in charge of the drug room and special treatment rooms, including metabolism. One supervisor has charge of the private room annex and the accident room, while the obstetrical supervisor has charge of the nursery and delivery room and is responsible for all supplies for that department. The night supervisor is in complete charge, of course, during the hours she is on duty.

Two people comprise the office staff, a bookkeeper and an information clerk. The information clerk meets the patients and turns them over to the supervisor of the department to which they are assigned. All admitting is done in the patients' room to which he goes immediately. The information clerk also has charge of the switchboard and does typing. The bookkeeper, in addition to her regular work, also does typing, files, makes out reports for the staff and board and admits patients each morning.

The front hall of the hospital. It is the duty of the flower committee to see that two flower arrangements are supplied the hospital each week.

The kitchen department comprises a cook, her assistant and one waitress. There are a house mother in the nurses' residence and a part-time maid. In addition to the students, who as part of their training do some of the housekeeping on the floors of the hospital, one general ward maid is provided. Two janitors are regularly employed. In the summer one works inside the building and the other takes care of the grounds. In the winter one works nights and the other days.

It's surprisingly simple and extremely effective. It couldn't be done by the 35 within if it were not for the 1500 without, all pulling together in a common interest. Collections, for example, run as high as 93 per cent, which, despite a good system, would never be possible if it were not for the fact that every one has the interest of the hospital at heart. But then, as we stated at the start, Emerson Hospital at Concord is actually a community hospital!

High Spots

Left: Old State House, Boston, in 1768, reproduced from a rare etching by Paul Revere. Below: Old South Church, erected in 1730, where meetings to resist the tax on tea were held. Benjamin Franklin was baptized therein.

IT'S going to be a busy week, make no mistake about it, what with page after page of your American Hospital Association program checked with sessions you wouldn't miss for anything. Then there are people you haven't seen for months, possibly since last year's meeting in Toronto. For several days, too, you'll be living amid historic spots about which you have read and forgotten more than you care to admit. Somehow our own history means more to us these days. Finally, say what you will about a busman's holiday, no sooner will you have been assigned to your room than you'll probably be contemplating a trip to some institution about which you have heard.

It's to be hoped that you have brought with you a pair of comfortable shoes, well broken in. You'll need them in your walks around the Mechanics Building where the exhibits are lined up ready for your inspection, bigger and better than ever, we are told. And there's just no use attempting to do any sight-seeing unless you're prepared to get out and walk. Incidentally, Mechanics Building itself is one of the old-timers of Boston, the scene of thousands of conventions and shows.

Some of the most interesting sights are right in the heart of the city within an hour of convention headquarters at the Statler.

If you take your sight-seeing seriously, a copy of "So This Is Boston" will prove an excellent traveling companion. You can pick it up in any book shop on Boylston Street, and it's small and handy to refer to when you're in doubt. Barring this, ask the next traffic cop the nearest way to Boston Common. If you don't experience a prickly sensation up and down your spine when you walk around the old Burying Ground, read the inscription on Bunker Hill Monument and examine the spot where the Boston Tea Party took place, there's something wrong somewhere.

Then there's Faneuil Hall, which you surely won't want to miss, to say nothing of the Old State House, the Governor's Mansion and the Otis Gray House. But you haven't seen anything yet! Before you finish with old Boston you'll want to browse around Old North Church and Paul Revere's home, to mention just a few of the important sights.

It can't all be done on a single early morning excursion, naturally. But having started your historical quest, you may be prompted to sneak out the side door of the Statler late some afternoon or take a trolley down from the Mechanics Building and finish in the cool of the day. What if your conscience does trouble you a bit by continually whispering, "Hospitals, hospitals"; we're coming to them later.

Whether you like fish or not, you won't regret strolling about the Boston Fish Pier—a sight to delight the eye, the nose, too, of any Middle Westerner. Incidentally, if he doesn't get a stomachful of sea food while he is in Boston, it will be no one's fault but his own. Although it has not come across the desk at this writing, the dietitians are said to be assembling complete information on places to eat. It would be well to make inquiries. They should know.

Perhaps you are not as interested in the poor fish on the wharf as you are in those who are suffering in the dark shadows of the narrow streets marking the financial district. You'll find yourself in the center of the greatest wool market in the world and, if the American Shoe Machinery Building is not the center of the shoe

in the "Hub"

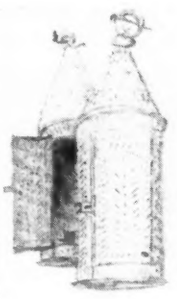
industry, it is so near it that no one could tell the difference. Yet they will tell you, and it's true, too, that New England has lost out industrially to the call of the South.

Well, we've done pretty well thus far—fish and finance. How about some Boston culture? There is the Boston Museum of Fine Arts about which you have heard and possibly have seen. Most people have to take museums in homeopathic doses. Boston has more museums than you can shake a stick at—the Museum of Natural History, Modern Museum of Fine Arts, Jack Gardner's Palace and a varied collection that is part of the Harvard group.

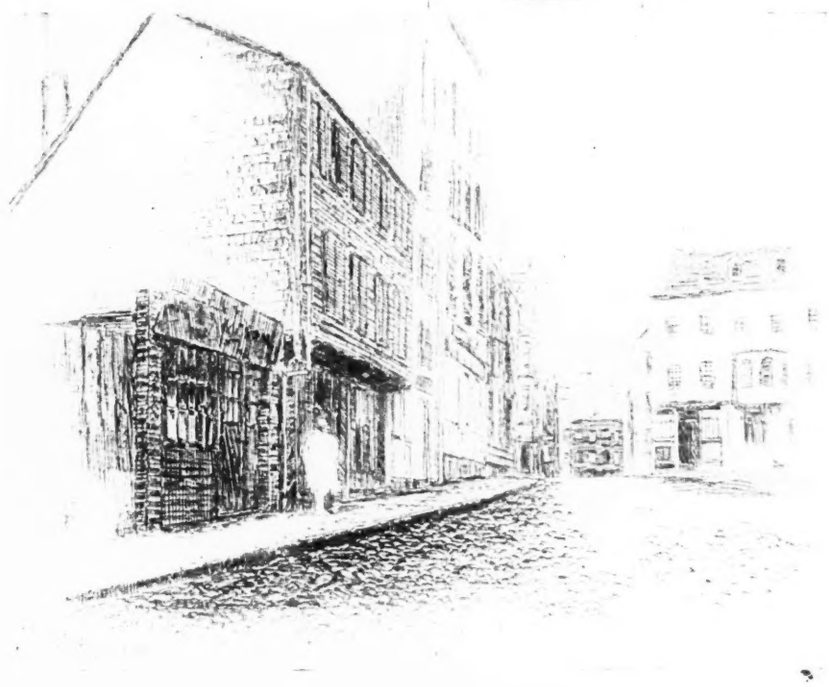
If museuming you go out Cambridge way, be sure to ask for the building containing the collection of glass flowers. There are the Fogg Museum at Harvard and the planetarium or conservatory, which, unless we have been misinformed, is open to visitors. Cambridge, also, has Longfellow's House, Lowell House and the Cambridge Hospital among its many spots of interest.

Did someone inquire about libraries? Surely we don't have to tell you about the Boston Public Library. That generally tops the sight-seer's list. There are others, too —the Widener Library, the Treadwell Library at Massachusetts General Hospital and the Boston Medical Library.

Right: Faneuil Hall, built in 1740, rebuilt in 1761. The large hall was the scene of all the great gatherings of the people previous to and during the Revolutionary War. Here Lee, Otis, Quincy, Adams, and Hancock addressed the colonists.



Below: Birthplace of Paul Revere, built in 1676 and still standing. Left: Lanterns used by Revere and Dawson to spread alarm.



We might have known it—mere mention of the word "hospital" and the old conscience gives us a bad turn again. It won't be long now. Just a minute or two while we finish up with religion. Did you know that Boston is the home of Unitarianism? You can see for yourself if you visit King's Chapel. First Church of Christ Scientist, the mother church, should certainly be on the list, and so should Old South Church.

It was when we were talking about the Treadwell Library at Massachusetts General that our conscience began cutting up. Let's start back at Massachusetts General. What a study in contrast are the old and the new, or, cutting out generalities, the Bulfinch Building, date 1821, *v.* the White Memorial Building, date 1939. Anyone who has not already seen it will want to inspect the old operating room in the dome of the Bulfinch Building; it is now used as

a museum and a meeting place for staff conferences. If he wants to study modern hospital construction, he will inspect carefully the new 11 story building that houses the administrative offices and, on the floors above, the surgical departments, including the main operating rooms, amphitheaters, x-ray plant and laboratories. Every building in this group has much to offer: Phillips House, for example, which caters to private patients only; Baker Memorial, which provides facilities for those of moderate means, and the Laboratory of Pathology. Incidentally, the Treadwell Library, already mentioned, will be found in the Moseley Memorial Building.

Successful Drug Store and Shop

Are you by chance interested in seeing what can be done with a hospital drug store and shop? Step inside New England Deaconess for a minute and look around you. The volume of business this drug store does is amazing! While here it would be time well spent to walk through the Palmer Memorial devoted to the treatment of cancer and chronic diseases, as well as the Baker Clinic, which is well known, of course, for its diabetic work.

There is a hospital staffed exclusively by women and run by women, too. That is something. You'll find it in the New England Hospital for Women and Children[1] founded years ago by a woman physician to assist women in the study of medicine. It might be well to check on what they are doing today in their prenatal work with mothers, yes, and fathers.

One of the nicest private patient pavilions to be found anywhere is Converse House at the New England Baptist Hospital out on Parker Hill. It's a climb, but what a view of the city! The rooms are attractively decorated and modern in every respect, the building having been opened only about three years.

The Boston Dispensary, you will discover, is the oldest private medical charity in the city. It is part of the New England Medical Center and is worth a visit for those who are interested in out-patient service. While there, be sure and look around the Joseph H. Pratt Diagnostic Hospital, which is a 62 bed unit built in 1938. It is particularly interesting for its plan of aiding physicians in their diagnostic problem and its general educational facilities. (See page 79.)

Peter Bent Brigham should be on the list, of course; it is practically a newcomer in point of years, yet it has contributed much toward medical education. In contrast to this institution opened in 1913, the Massachusetts Memorial Hospital will soon be completing its seventieth year of service. Again, it is suggested that those who are interested in out-patient work see what is being done to check admissions in this department. Modernization as applied to these buildings has included some air conditioning that might be investigated to advantage.

You don't have to go outside of the Boston city limits to find what a community hospital can do in a metropolitan area. Faulkner Hospital[2] has for years been running Sunday afternoon health talks which have literally had them standing in the aisles. This institution has also pioneered in organizing an anesthesia department under the supervision of a medical anesthetist.

Last, but not least, is Boston City Hospital, which you will be told, if you do not already know it, is the largest general hospital for acute diseases in New England. According to the latest figures it has approximately 2000 beds in the main building, 300 beds for contagious diseases and 625 beds in its tuberculosis division at Mattapan. Here you can see 20 operating rooms in one building, the Dowling unit, also an amphitheater that accommodates 300 students.

It is not so easy to get out of town during convention days with meetings going on morning, noon and night and various social events scattered in between. But how about taking a day or two, either before or after the big show, to roam the countryside learning as you ride. You're still in historic country, with plenty of interesting sights including some excellent small hospitals.

It won't take you more than thirty minutes to drive by car or bus out to Concord — we're still in Massachusetts—to see the battlefields and the homes of such great Americans as Hawthorne, Louisa Alcott and Thoreau, to say nothing of Emerson Hospital, about which you can read elsewhere in this issue.

You'll never regret a trip to Gloucester either, probably about an hour and a half by motor. . . . The countryside is beautiful and a fascinating fish town greets you. The Addison Gilbert Hospital[3] is there, too, a short way from town overlooking the salt marshes, which are particularly colorful in the fall. Step in and admire some of the fine old antiques that make the building seem so much a part of the community. And whatever happens, don't miss the roof. It looks for all the world like the deck of an old whaler with its savage looking musket, ship's lantern and other accessories to give it the hallmark of seafaring tradition.

Before you leave Gloucester breathe deep the salty, sweet air from the sea as you stand behind the fishermen at the head of the bay. Having gone that far you'll never regret driving up the coast a mile or two farther to Rockport and strolling around the art colony with its gay little shacks dotting the tongue of land that stretches out into the water.

Tobey Hospital Worth Visit

Should you be traveling to Wareham, take time out to inspect the brand new Tobey Hospital. No money was spared to make this all that a small hospital should be. The chances are you'll find the town still gasping a bit over the excitement of having for the first time in its history any hospital at all, let alone such a completely modern one. Perhaps it's only fair to prepare you by the picture on the front cover.

There is so much to see in this fascinating countryside and, as you'll soon discover to your regret, so little time in which to become acquainted with even a part of it. But you'll be returning for another "high-spotting" tour of the "Hub" and its historic setting. Everyone does sooner or later.

[1]All for the Ladies, The MODERN HOSPITAL **50:**78 (June) 1938.

[2]A Workshop for Health, The MODERN HOSPITAL **46:**60 (June) 1936.

[3]Addison Gilbert of Gloucester, The MODERN HOSPITAL **49:**44 (Oct.) 1937.

A. H. A. Convention Program

Boston, Sept. 16-20

THE surgeons general of the United States Army, the United States Navy and the United States Public Health Service are expected to attend the Boston convention of the American Hospital Association and allied organizations this month and to participate in a session devoted to the hospital's part in preparedness. This session, to be held on Thursday afternoon, will probably be the highpoint of what promises to be one of the outstanding conventions in A.H.A. history.

Features of special interest include an evening session and two afternoon round tables devoted to women's auxiliaries, an evening session on trustee problems and the first meeting of a new section of the association on interns and residents.

The program which follows includes a wide variety of topics of current interest. Inclusive rate plans, for example, are to be discussed on different programs. Hospital service plans will be the subject of one general meeting and several meetings for executives. The round table by Dr. Malcom T. MacEachern on Friday morning will again act as a fitting conclusion to the convention.

A total of 56 educational exhibits and 160 technical exhibits will pack Mechanics Hall. Among the technical exhibitors are many who have long been identified with the hospital field. A tabulation of the exhibits indicates that hospital supply, equipment and specialty organizations lead the parade with 18 firms. Close on their heels is the group offering furniture and furnishings 15 of which will be represented. Particularly notable in the A.H.A. exhibit is the increased participation by the manufacturers of pharmaceutical products, eight of whom will be on hand.

Other important groups that will exhibit and the number of firms participating are as follows: sterilizers, 4; rubber gloves, 4; textiles, blankets and garments, 6; fracture appliances, 2; surgical dressings, sutures and ligatures, 5; rustless metals, 3; surgical and medical equipment and supplies, 8; oxygen and oxygen administration apparatus, 4; respiratory equipment, 2; intravenous solutions and equipment, 2; ambulances, 1; physical therapy equipment, 1; clinical photography, 1; food products, 8; x-ray equipment, 4; casters and wheeled equipment, 4; signal systems, 3; kitchen machines and cooking utensils, 5; floor machines, 3; cleansing agents, 7; placement bureaus, 5; construction materials, 8; laundry machinery and supplies, 4; publishers, 10; diagnostic and surgical instruments, 8, and mattresses, 3. The 160 firms in the technical exhibit will occupy 256 booths.

MONDAY, SEPT. 16

Dietetic Section

Talbot Hall, 2-4 p. m.

Chairman: Joe R. Clemmons, M.D., New York; *Secretary:* Lenna F. Cooper, New York.

Address: A Nutritional Study of Hospital Diets, T. T. Mackie, M.D., and Dorothy DeHart, New York, dietetics editor, The MODERN HOSPITAL.

Address: Are Special Diets Overdone? Mary Ruth Curfman, supervising dietitian, St. Luke's Hospital, New York.

Panel Discussion: Alta M. Atkinson, New York, chairman. Topics: Tools for Management, Training for Supervision, Training the Personnel and Rating the Employe.

Panel Members: Bertha E. Beecher, Cincinnati; Douglas V. Brown, Boston; Mrs. Chester C. Dodge, Boston; J. E. Doyle, West Lynn, Mass., and Maniza Moore, Boston.

Hospital Service Plan Session

Warren Hall, 2-4 p. m.

Chairman: Frank Van Dyke, New York.

Address: Recent Developments in Hospital Service Plans, C. Rufus Rorem, Ph.D., Chicago.

Address: Next Steps in Hospital Service Plans, S. S. Goldwater, M.D., president, Associated Hospital Service of New York.

Address: Hospital Plans and Industrial Health, Roy W. Kelly, Boston.

Pharmacy Section

Reverend Jens Hall, 2-4 p. m.

Chairman: Worth L. Howard, Akron, Ohio; *Secretary:* Eldon Roberts Jr., Richmond, Va.

Address: The Universities Accept Their Responsibility for Training Hospital Pharmacists, Dean W. F. Rudd, Richmond, Va.

Address: Cost *v.* Service, I. T. Reamer, Durham, N. C.

Address: Relationship of the Pharmacist to Other Professional Groups, R. K. Lager, Cleveland.

Address: What the Medical Superintendent Expects of His Pharmacist, D. M. Morrill, M.D., Detroit.

Address: The Formulary System, Don Clark, New York.

Social Service Section

Louie Hall, 2-4 p. m.

Chairman: Frank J. Walter, Denver; *Secretary:* Harriet M. Bartlett, Boston.

Symposium: Is the Social Service Department the Logical Bridge Between the Voluntary Hospital and the Government? Charles F. Wilinsky, M.D., Boston; Ethel Cohen, Boston; Donald C. Smelzer, M.D., Philadelphia, and Martha M. Eliot, M.D., Washington, D. C.

Symposium: What Is Social Service? Where Does It Begin and Where Does

It End? Ida M. Cannon, Boston; Elizabeth P. Rice, New Haven, Conn.; Edwin L. Harmon, M.D., Valhalla, N. Y.; A. C. Bachmeyer, M.D., Chicago, and F. Stanley Howe, Orange, N. J.

President's Session

Ballroom, Hotel Statler, 8-9:30 p. m.

Chairman: Fred G. Carter, M.D., Cleveland.

Addresses of Welcome: Maurice J. Tobin, Mayor of Boston; Charles F. Wilinsky, M.D., New England Hospital Assembly, and Oliver G. Pratt, Massachusetts Hospital Association.

Address of the President: Fred G. Carter, M.D., Cleveland.

Response by President-Elect: Benjamin W. Black, M.D., Oakland, Calif.

Presentation of A.H.A. Annual Award of Merit to Dr. S. S. Goldwater; Msgr. M. F. Griffin, Cleveland.

Presentation of National Hospital Day Awards: Albert G. Hahn, Evansville, Ind.

Reception: Delegates, their wives and friends.

TUESDAY, SEPT. 17

Hospital Service Plan Round Table

Warren Hall, 9-11 a. m.

Coordinator: Abraham Oseroff, Pittsburgh.

Topic: Interdependence of Hospitals and Hospital Service Plans, N. W. Faxon, M.D., Boston.

Discussants: A. J. Hockett, M.D., New Orleans; Lewis E. Jarrett, M.D., Richmond, Va.; E. W. Jones, Albany, N. Y.; John R. Mannix, Detroit; John A. McNamara, Cleveland; Ada Belle McCleery, R.N., Evanston, Ill.; Frank Van Dyk, New York; E. A. van Steenwyk, Philadelphia, and Peter Ward, M.D., St. Paul, Minn.

Out-Patient Section

Louie Hall, 9-11 a. m.

Chairman: Ray Amberg, Minneapolis; *Secretary:* W. T. S. Thorndike, M.D., Boston.

Address: Professional Organization of Clinics to Obtain Coordinated Service in Diagnosis and Treatment of Patients and Personal Relationship With Physicians, Allan Butler, M.D., Boston.

Discussant: W. A. O'Brien, M.D., Minneapolis.

Address: Medical Services in the Home. Should Out-Patient Department Extend Its Services to the Home? Thomas Broadie, M.D., St. Paul.

Discussant: Frank E. Wing, Boston.

Symposium: The Out-Patient Problem in the Small Town, Ruth Cook Wilson, Moncton, New Brunswick, and W. A. Copeland, Warsaw, N. Y.

Discussant: Graham L. Davis, Battle Creek, Mich.

Address: Economies in Out-Patient Organization and Administration, John E. Ransom, Baltimore.

Discussant: Albert Scheidt, Chicago.

Tuberculosis Section I

Talbot Hall, 9-11 a. m.

Chairman: E. S. Mariette, M.D., Oak Terrace, Minn.; *Secretary:* H. McLeod Riggins, M.D., New York.

Symposium: The Detection of Unidentified Tuberculosis in the General Hospital, Robert E. Plunkett, M.D., Albany, N. Y.; Edward X. Mikol, M.D., Albany, N. Y., and Edward T. Thompson, M.D., Milwaukee.

Discussant: Donald S. King, M.D., Boston.

Symposium: The Tuberculosis Problem in Mental Hospitals, H. E. Hilleboe, M.D., St. Paul, Minn., and Maxim Pollak, M.D., Peoria, Ill.

Address: Future Trends in the Care of the Tuberculous, Paul H. Fesler, Nopeming, Minn.

Business Management Section

Warren Hall, 2-4 p. m.

Chairman: George A. MacIver, M.D., Worcester, Mass.; *Secretary:* Carl A. Lindblad, Providence, R. I.

Demonstration of Purchasing Routine: L. M. Arrowsmith, Brooklyn, N. Y.

Address: Supply Services and Efficiency Control, Charles F. Wilinsky, Boston.

Address: The Doctor and Nurse as an Aid in Economical Use of Hospital Equipment and Supplies, Dennett L. Richardson, M.D., Providence, R. I.

Address: Pension and Life Insurance for Hospital Employes, Edgar C. Hayhow, Paterson, N. J.

Panel Discussion: Inclusive Rates.

Discussants: L. H. Chadburn, Hillsdale, Mich.; James A. Hamilton, New Haven, Conn., and Ada Belle McCleery, Evanston, Ill.

Children's Hospital Section

Louie Hall, 2-4 p. m.

Chairman: D. L. Richardson, M.D., Providence, R. I.; *Secretary:* Joelle C. Hiebert, M.D., Lewiston, Me.

Address: Hospitalization of Contagious Diseases, or Central Hospital Units Serving Larger Areas, Conrad Wesselhoeft, M.D., Boston.

Discussant: Col. Edward G. Huber, M.D., Boston.

Address: Trends in Pediatrics, James L. Wilson, M.D., Detroit.

Address: The Kiwanis Club and Underprivileged Children in Hospitals, William J. Carrington, M.D., Atlantic City, N. J.

Address: Standards for the Care of New-Born and Premature Infants in Hospitals, Marian M. Crane, M.D., Washington, D. C.

Round Table: Hospitals Working Together for Children, section officers, previous speakers and Samuel Proger, M.D., Boston.

Tuberculosis Section II

Talbot Hall, 2-4 p. m.

Chairman: E. S. Mariette, M.D., Oak Terrace, Minn.; *Secretary:* H. McLeod Riggins, M.D., New York.

Symposium: The Rôle of the General Hospital in the Control of Tuberculosis, John Hayes, New York; Theodore L. Badger, M.D., Boston; Monroe J. Tanner, M.D., Ridgewood, N. J.; Alice L. Spellman, Albany, N. Y.; Katharine G. Amberson, Albany, N. Y., and Richard H. Overholt, M.D., Boston.

Discussant: David Cooper, M.D., Philadelphia.

Trustees' Section

Ballroom, Hotel Statler, 7:30-9 p. m.

Chairman: Raymond P. Sloan, New York; *Secretary:* C. R. Burnett, Newark, N. J.

Address: A Trustee Looks at Hospital Finances, Tracy S. Voorhees, Brooklyn, N. Y.

Address: What the Trustee Expects of His Administrator, Samuel Stewart, Lewiston, Me.

Address: What the Administrator Expects of Her Trustees, Frances C. Ladd, R.N., Jamaica Plains, Mass.

Address: Staffing the Community Hospital, speaker to come.

Address: How to Achieve the Ideal Hospital Board, Oliver G. Pratt, Salem, Mass.

WEDNESDAY, SEPT. 18

Administration Section I

Paul Revere Hall, 9-11 a. m.

Chairman: Albert W. Buck, Ph.D., Torrington, Conn.; *Secretary:* O. K. Fike, Washington, D. C.

Symposium: The Personnel Problem, James B. Slimmon, Hartford, Conn.; Glenwood J. Sherrard, Boston, and Bertha E. Beecher, Cincinnati.

Discussant: Edgar C. Hayhow, Paterson, N. J.

Address: Flat Rates, F. V. Altvater, Durham, N. C.

Discussants: James V. Class, C.P.A., Cleveland, and Joe R. Clemmons, M.D.

Administrators' Conference: Warren F. Cook, M.D., William B. Nash, Sadie A. Hagen, Rosina Vance, Donald Sabine, Mrs. C. M. Keatley, Leon T. Cooke, Marjorie B. Davis, Shields Warren, M.D., Howard Pringle, C. D. Tutein, Mrs.

Gertrude Jameson and Joseph H. Marks, M.D.

Construction and Mechanical Section

Reverend Jens Hall, 9-11 a. m.

Chairman: A. J. Hockett, M.D., New Orleans; *Secretary:* Lewis E. Jarrett, M.D., Richmond, Va.

Address: Modern Trends in Hospital Construction, Edward F. Stevens, Boston.

Discussant: Claude W. Munger, M.D., New York.

Address: Modernization of the Power Plant in the Hospital, Arthur H. Perkins, M.D., Norfolk, Va.

Discussant: Arden E. Hardgrove, Louisville, Ky.

Address: Decentralized Ice Making, Albert Snoke, M.D., Rochester, N. Y.

Discussant: Ray Amberg, Minneapolis.

Address: Plumbing and Pollution Dangers in the Hospital, Dean Francis Dawson, Iowa City, Iowa.

Discussant: L. M. Arrowsmith, Brooklyn, N. Y.

Public Relations Round Table

Warren Hall, 9-11 a. m.

Chairman: Michael M. Davis, Ph.D., New York.

Address: How Hospitals Can Build Public Good Will, Edward L. Bernays, New York.

Address: An Outsider Looks at Hospitals, Homer W. Borst, New Haven, Conn.

Discussion: Small panel of administrators.

Administration Section II

Reverend Jens Hall, 2-4 p. m.

Chairman: Oliver G. Pratt, Salem, Mass.; *Secretary:* N. A. Wilhelm, M.D., Boston.

Address: Rural Hospital Program, Graham L. Davis, Battle Creek, Mich., and Claude W. Munger, M.D., New York.

Symposium: Miriam Curtis, Northampton, Mass.; Harold T. Prentzel, Philadelphia; G. Harvey Agnew, M.D., Toronto.; R. F. Cahalane, Boston, and Chester H. Lang, Schenectady, N. Y.

Governmental Hospital Section

Talbot Hall, 2-4 p. m.

Chairman: George P. Bugbee, Cleveland; *Secretary:* Henry Hooper, Cincinnati.

Address: Aid to Governmental Hospitals Under Public Relief Programs, P. J. McMillin, Baltimore.

Discussants: E. M. Dunstan, M.D., Dallas, Tex., and T. K. Gruber, M.D., Eloise, Mich.

Address: What Is Hospital Indigency? Charles F. Wilinsky, M.D., Boston.

Discussant: Edwin L. Harmon, M.D., Valhalla, N. Y.

Address: Specifications and Government Purchasing, H. N. Hooper, Cincinnati.

Discussant: William L. Coffey, Wauwatosa, Wis.

Address: Public Hospital Organization and Control, James A. Hamilton, New Haven, Conn.

Discussant: Herman C. Loeffler, Boston.

Nursing Section

Warren Hall, 2-4 p. m.

Chairman: Nathaniel W. Faxon, M.D., Boston; *Secretary:* Bertha W. Allen, Newton Lower Falls, Mass.

Address: Accrediting Nursing Schools, Clara Quereau, New York.

Address: Planning Sound Educational Programs Leads to Good Nursing Service, Grace Warman, New York.

Address: Public Support of Nursing Education: Financial and Moral, Hans Zinsser, M.D., Boston.

Women's Auxiliary Session

Ballroom, Hotel Statler, 8 p. m.

Chairman: Betty Dumaine, Boston.

Address: Growth of Volunteer Service and Its Place in Hospitals Today, Mrs. Frank A. Vanderlip, New York.

Address: Need for Trained Volunteers and Where Responsibility Should Be, Beatrice F. Meyer, New York.

Address: Opportunities for Women in Hospital Service, Mrs. N. H. Whitman, Boston.

THURSDAY, SEPT. 19

Small Hospital Section

Massachusetts Institute of Technology, 9-9:45 a. m.

Demonstration: Anesthetic Gas Explosions.

Convention Hall, 10-11 a. m.

Chairman: Jewell W. Thrasher, Dothan, Ala.; *Secretary:* Marjorie Buck, Simcoe, Ont.

Address: Credits and Collections in a Small Hospital, Robert S. Hudgens, Atlanta, Ga.

Address: Procedure Books and Standing Orders, Mrs. Gertrude T. Haynes, Augusta, Ga.

Address: Program for the Development of Floor Nursing and Supervision, Lulu K. Wolf, Nashville, Tenn.

Round Table.

Intern and Residency Section

Talbot Hall, 9-11 a. m.

Chairman: Joseph G. Norby, Milwaukee; *Secretary:* Donald C. Smelzer, M.D.

Address: General Principles of an Educational Program for Interns and Residents, Willard C. Rappleye, M.D., New York.

Address: The Content and Management of a Program of Education of Interns and Residents in a Small Hospital, Stanley J. Seeger, M.D., Milwaukee.

Address: Graduate Training in Surgery, Edward D. Churchill, M.D., Boston.

Address: The Residency Program in Conjunction With the Graduate School of Medicine, Donald Guthrie, M.D., Sayre, Pa.

Women's Auxiliary Round Tables

Hotel Statler, 2-4:30 p. m.

Round Table I: Mrs. Andre V. Cherbonnier, New York, presiding.

Topic: Volunteer Training and Placement, Mrs. Thomas Armitage, New York; Harriet A. Robeson, Boston; Eleanor Morris, Philadelphia, and Mrs. James Donovan, Boston.

General Discussion.

Round Table II: Mrs. Nehemiah H. Whitman, Boston, presiding.

Topic: Committees, Dean Jane Louise Mesick, Simmons College; Mrs. Harold Stanley, New York; Mrs. W. J. Baker, Rochester, N. Y.; Mrs. David B. Arnold, Boston; Mrs. O. W. Rhynas, Burlington, Ont.

General Discussion.

General Session on Preparedness

Warren Hall, 2-4 p. m.

Chairman: Fred G. Carter, M.D., Cleveland.

Address: Preparedness From the Point of View of the Navy, Surgeon General Ross T. McIntire, rear admiral.

Address: Preparedness From the Point of View of the Army, Major General James C. Magee.

Address: Preparedness From the Point of View of Public Health, Surgeon General Thomas Parran.

Banquet and Ball

Ballroom, Hotel Statler, 7:30 p. m.

Toastmaster: Fred G. Carter, M.D., Cleveland.

Address: William Austin O'Brien, M.D., director, Department of Postgraduate Medical Education, University of Minnesota.

Induction of President.

Ball.

FRIDAY, SEPT. 20

General Round Table

Georgian Room, Hotel Statler, 9:30-11:30 a. m.

Coordinator: Malcolm T. MacEachern, M.D., Chicago.

A.C.H.A. Convention Program

Sept. 14 to 16

THE last seven administrators to be elected directly to fellowship in the American College of Hospital Administrators will be inducted at the convocation on Sunday afternoon, September 15, at the Hotel Statler.

The A.C.H.A. credentials committee, meeting in July, selected the following persons for that honor: Mother Marie Rose (Audet), superintendent of Hotel Dieu Hospital, Campbellton, New Brunswick; Frances Chappell, superintendent, North Country Community Hospital, Glen Cove, N. Y.; William H. Harper, house governor, Royal Hospital, Wolverhampton, England; Curtis H. Lohr, M.D., superintendent, St. Louis County Hospital, Clayton, Mo.; Joseph R. Morrow, M.D., superintendent, Bergen Pines County Hospital, Ridgewood, N. J.; Carl O. Pedersen, superintendent, Norwegian Lutheran Deaconesses' Home and Hospital, Brooklyn, N. Y., and Louise H. Thompson, superintendent, Elliott Community Hospital, Keene, N. H.

Seventy-eight administrators have been elected directly to membership this year and 43 have been elected to associate membership. Thirty-three are being advanced to fellowship and six are being advanced to membership.

Honorary fellows also have been named but their acceptances have not yet been received at A.C.H.A. headquarters. Dr. Frederic A. Washburn will deliver the convocation address.

The convention program, as of the date of August 23, follows:

SATURDAY, SEPT. 14

Hotel Statler

11 a.m.: Executive committee meeting, College Headquarters Suite.

1 p.m.: Luncheon meeting, Board of Regents, Hancock Room.

SUNDAY, SEPT. 15

Hotel Statler

All Day: Registration, mezzanine floor.

10:30 a.m.: General business session, Georgian Room.

2 p.m.: Convocation rehearsal, Ballroom.

3 p.m.: Convocation, Ballroom. Dr. Frederic A. Washburn, Boston, speaker.

7 p.m.: Banquet, Ballroom. President Charles Seymour of Yale University, speaker.

9 p.m.: President's reception, Ballroom Assembly.

MONDAY, SEPT. 16

Mechanics Hall and Hotel Statler

10 a.m.: General educational session, Mechanics Hall. A. C. Bachmeyer, M.D., chairman.

Address: Analysis and Development of Personality.

Address: How to Determine Effectiveness as an Administrator.

Address: How to Develop Sources of Information, Gerhard Hartman.

Address: How to Prepare Oneself to Write for Publication, Alden B. Mills.

Round Table: Existing Educational Courses Available for Administrators, conducted by Malcolm T. MacEachern, M.D.

1 p.m.: Luncheon meeting, Board of Regents, Hancock Room, Hotel Statler.

4 p.m.: Executive committee meeting, College Headquarters Suite, Hotel Statler.

Protestant Program

CONVENTION THEME: "At work with the Master Physician in the Protestant Hospital."

FRIDAY, SEPT. 13

Copley Plaza Hotel

Registration, 3 p.m., and *Officers' and Trustees' Dinner,* 5 p.m.

Sheraton Room, 7:30 p.m.

Chairman: Rev. Paul R. Zwilling, St. Louis.

Devotions: Rev. Joseph George, Chicago.

Address of Welcome: Dr. Warren F. Cook, Boston.

Address: Resumé of the Year's Work, President Zwilling.

Address: Looking Forward, Guy M. Hanner, Colorado Springs, Colo.

Reports of Officers.

SATURDAY, SEPT. 14

Sheraton Room, 9:30 a.m.-12:15 p.m.

Chairman: Dr. E. M. Dunstan, Dallas, Tex.

Address: Standards of a Chaplain in a General Hospital, Russell L. Dicks, Chicago.

Address: Why Should a Church Hospital Meet the Standards and Requirements of the American College of Surgeons? Malcolm T. MacEachern, M.D., Chicago.

Address: Can a Christian Nurse Do Personal Evangelism in a Hospital? Ara Davis, Temple, Tex.

Address: Shall the Church Hospital Arrange for Social Security for Its Employes? E. I. Erickson, Chicago.

Address: Protestant Hospitals Around the World, N. E. Davis, D.D., Columbus, Ohio.

Address: How Does Hospital Care Insurance Help the Church Hospital Care for Charity Cases? Bryce L. Twitty, Dallas, Tex.

Sheraton Room, 2:30-4 p.m.

Chairman: John H. Olsen, Prince Bay, N. Y.

Address: Can a Hospital Refuse to Care for Charity Cases and What Percentage of Charity Work Can a Hospital Assume? Robert E. Neff, Iowa City, Iowa.

Address: How Can Hospitals of all Denominations Cooperate in a Community? Albert H. Scheidt, Chicago.

Address: Public Relations as They Relate to Church Hospitals, Alden B. Mills, Chicago.

Tea: Deaconess Hospital, sponsored jointly by Deaconess and Baptist hospitals.

Banquet, 7 p.m.

Greetings: From presidents of other hospital organizations.

Address: Rt. Rev. Henry K. Sherrill, D.D., Bishop of the Diocese of Massachusetts.

Presentation of New Officers and Trustees.

SUNDAY, SEPT. 15

Sheraton Room, 9:30 a.m.

Chairman: Rev. Clinton F. Smith, Chicago.

Address: Rev. C. O. Pederson, Brooklyn, N. Y.

New Service for Small Hospitals

SAMUEL PROGER, M.D.

THE primary purpose of the Joseph H. Pratt Diagnostic Hospital in Boston is to develop a program of postgraduate education through a hospital-medical school center that will serve as a model for the more effective distribution of better medical care.

While this program operates specifically through the Joseph H. Pratt Diagnostic Hospital, the base of operations is the New England Medical Center, which consists of the Boston Dispensary, the Boston Floating Hospital and Tufts College medical and dental schools.

The activities herein described constitute part of the general program of the Bingham Associates Fund for the Advancement of Rural Medicine and the work is fully subsidized by this fund.

There are now 22 hospitals in Maine that are affiliated with the Joseph H. Pratt Diagnostic Hospital under the hospital extension plan which operates through regional centers at Lewiston (Central Maine General Hospital) and Bangor (Eastern Maine General Hospital).

The services that these hospitals receive through their affiliation with us include instruction in radiology, pathology, electrocardiography, dietetics; courses for technicians, and exchange service on current medical journals.

The x-ray service plan in the Bangor group has been inaugurated only recently. Seminars are held every two weeks at the Eastern Maine General Hospital in Bangor and are attended by the radiologists from the smaller community hospitals. Traveling expenses are covered by the Bingham Associates Fund. All routine films are sent to the central hospital in Bangor before the seminar so that consultation notes have already been dictated on them and those of particular interest have been chosen in advance for discussion. Thus, problems with which the radiologists are immediately concerned and those with which they should be kept familiar are discussed.

This program for improving small hospital service can be modified and adapted to the needs of other communities. Interested administrators and officers of state hospital associations are invited to visit Doctor Proger at the hospital on Monday, September 16, from 4 to 6 p.m.

In the interval between the seminars, emergency films can be sent in for examination; occasionally the Bangor radiologist visits the local hospitals to give them help and to familiarize himself with their equipment and facilities. The central radiologist also attends the radiological seminars at the Massachusetts General Hospital in Boston as often as is possible.

Every two months the x-ray technicians meet in Bangor for a conference on their own problems. They are also given fellowships for periods of study in Boston when and as they need them. The radiologist at the Eastern Maine General Hospital has an opportunity at the seminars to see what technical faults should be corrected and he takes up these points with the technicians at their conference.

In the Lewiston group the central radiologist visits the affiliated hospitals once a week; otherwise the program is essentially the same as in the Bangor group. The Bangor plan seems to be more promising, however, as it is capable of reaching an unlimited number of hospitals in a large area and geographical factors are minimized.

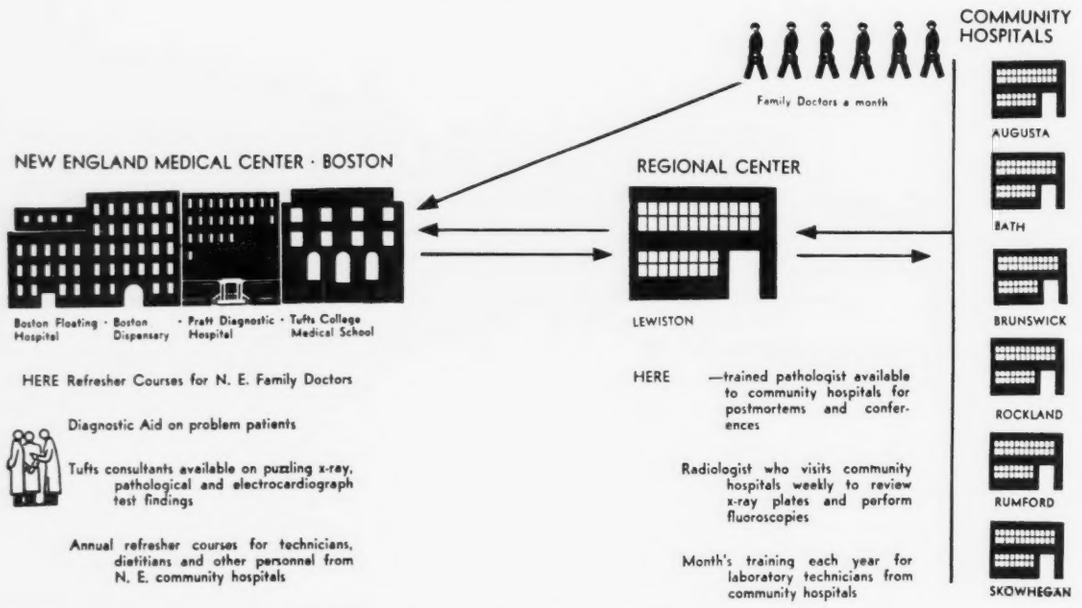
Pathology is a highly specialized subject and it is impracticable for a physician to practice part-time pathology as he can radiology. Smaller community hospitals, therefore, have no local pathologists. Hence, all tissue specimens are routinely sent from the small hospital to the central hospital, which thereby accumulates enough material to occupy a full-time pathologist. He sends back an immediate report, by telephone when necessary, and all questionable specimens are sent on to the head of the pathology department at Tufts, who is at all times available for consultation. Slides are gladly reviewed with the interested physician upon request. Postmortem examinations at the affiliated hospitals have also been performed by the central pathologist in an increasing number of cases, an excellent indication of growing interest on the part of local practitioners.

Any physician who is interested in electrocardiography can take a week's course given by the postgraduate division and thereafter he can send duplicate tracings on all electrocardiograms to the central hospital. He makes his own diagnosis and then receives the central hospital report as a checkup. Problem tracings may be sent on to Boston by the central hospital when necessary.

Dietitians from the affiliated hospitals are given scholarships to take one month courses annually in hospital dietetics at either the Joseph H. Pratt Diagnostic Hospital (hospital dietetics) or the Boston Dispensary (food clinic training). A survey is now being made of the dietetics departments in the affiliated hospitals and interest in this important subject is rapidly growing.

Scholarships are granted to x-ray, clinical and tissue pathology and chemistry laboratory technicians for advanced and specialized studies, chiefly in the laboratories of the Joseph H. Pratt Diagnostic Hospital.

The author is medical director of the Bingham Associates Fund and Joseph H. Pratt Diagnostic Hospital, Boston; chairman, committee on postgraduate medical education, Tufts Medical School, and clinical professor of medicine, Tufts Medical School.


HORIZONTAL DEVELOPMENT of N. E. MEDICAL CENTER
Working Model now in operation in Central Maine
COMMUNITY HOSPITALS
Family Doctors a month
NEW ENGLAND MEDICAL CENTER · BOSTON
REGIONAL CENTER
AUGUSTA
BATH
BRUNSWICK
ROCKLAND
RUMFORD
SKOWHEGAN
Boston Floating Hospital
Boston Dispensary
Pratt Diagnostic Hospital
Tufts College Medical School
LEWISTON
HERE Refresher Courses for N. E. Family Doctors
Diagnostic Aid on problem patients
Tufts consultants available on puzzling x-ray, pathological and electrocardiograph test findings
Annual refresher courses for technicians, dietitians and other personnel from N. E. community hospitals
HERE —trained pathologist available to community hospitals for postmortems and conferences
Radiologist who visits community hospitals weekly to review x-ray plates and perform fluoroscopies
Month's training each year for laboratory technicians from community hospitals

Other community hospitals in the Lewiston group are located in the following towns: Lewiston, Camden and Waterville. Those included in the Bangor group are located at Bangor, Greenville, Dover-Foxcroft, Belfast, Blue Hill, Castine, Bar Harbor, Machias, Lubec, Calais and Island Falls.

Technicians in each small hospital spend one month out of the year in Boston for the purpose of improving their technic and of learning new methods and procedures. An "itinerant technician" is provided to substitute in the affiliated hospital for the duration of the course. During the fiscal year 1939-40, 27 such scholarships for technicians were awarded.

In addition, a week's course in chemistry was given last winter by the chief chemist of the Joseph H. Pratt Diagnostic Hospital at the Central Maine General Hospital for the technicians of the Lewiston group. Attendance at its sessions was high; demonstrations, appraisals and criticisms of methods were carried out.

In the attempt to standardize laboratory procedures, many of the hospital laboratories are given solutions of the various reagents used in tests from the central laboratories. By means of this arrangement the number of variable factors is reduced and accurate results are more easily obtainable in the small community hospitals.

The Gerrish Library at the Central Maine General Hospital serves as a central medical library for the entire Lewiston group. It works up bibliographies and sends out books for practitioners in 24 towns, and conducts a regular mailing service on current journals. By this system, five hospitals (as of May 1940) regularly receive selected current medical journals which they send on to the next hospital at the end of four days.

The activities of the postgraduate division of Tufts Medical School fall under the headings of postgraduate courses, teaching ward rounds in affiliated hospitals, follow-up correspondence service, the bulletin of the New England Medical Center and hospital case teaching.

Seventeen one-week courses were given during the academic year, 1939-40, in allergy, anesthesiology, cancer, dermatology, electrocardiography, endocrinology, gynecology, hematology, proctology and radiology. In addition, seven one-month courses were given in internal medicine, pediatrics, obstetrics and gynecology.

The total enrollment for these courses was 112 physicians, 67 of whom received Bingham fellowships. These fellowships are available to members of the Maine Medical Association. The tuition for all courses, however, is placed at a level calculated to make them available to the great body of physicians in New England.

Once a month various Boston specialists, chosen by the men they are to visit, go to the participating hospitals to conduct teaching ward rounds. The particular advantage of such a system is that the practitioner's own cases, in which he is necessarily interested, are used as the basis for teaching by the specialist.

In an effort to keep our teaching from ending with the course taken or the ward rounds attended, a system of follow-up letters has been developed. Every doctor who attends teaching ward rounds subsequently receives a letter that sums up the most interesting points of the cases seen and gives pertinent references in the literature. The physicians who have attended postgraduate courses receive similar letters at intervals, telling of interesting cases that have been seen since they took the course and reviewing the current literature and latest advances.

The bulletin of the New England Medical Center is published every two months and distributed to Tufts medical alumni and to all physicians who have been affiliated with us. It contains brief abstracts of the morning conference lectures at the Joseph H. Pratt Diagnostic Hospital.

Whenever possible teaching material is sent along with the hospital case report on referred patients. This material consists of pertinent abstracts, references to literature and reprints and, inasmuch as it deals with a clinical problem of immediate interest to the referring physician, it has special teaching value.

Control of Operating Rooms

CONTROL of the operating room presents many problems and sometimes leads to major crises if definite rules for operating room procedure are not set up and enforced. So much discussion has arisen over such points as priority in scheduling operations, recording preoperative diagnoses and restraining aspiring surgeons with more zeal than talent that a survey was made to obtain answers to the questions listed in the accompanying box.

The opinions rendered by this month's board of experts vary widely on some questions and little on others. They speak for themselves as follows:

THE QUESTIONS

1. **How are operations scheduled? By whom?**
   How do you avoid favoritism in scheduling time for operations?
2. **Do you require that a preoperative diagnosis be recorded?**
   Who enforces this rule?
   Do you have any difficulty in or any good method of enforcing it?
3. **Can any licensed physician in the community undertake surgery in your hospital? What restrictions do you have?**
4. **Do you permit either a registered or a student nurse to act as first assistant? What is your requirement? Do you make an exception in emergency surgery on holidays or at night?**

• CRAIG BARROW, M.D., *Central of Georgia Railway Hospital, Savannah, Ga.* (62 *beds*).

1. Operations are posted by staff members and assigned by the operating room staff.
2. We do require that a preoperative diagnosis be recorded before the operation. The chief surgeon enforces this rule.
3. Only staff members.
4. Nurses are not permitted to act as first assistants at operations. Either an intern or a member of the surgical staff must be the assistant.

• FREADA K. BUTTS, R.N., *Emma L. Bixby Hospital, Adrian, Mich.* (40 *beds*).

1. All operations are scheduled in the admitting office and the surgical nurse is given a copy of the schedule. The hours for operations are 8 a.m., 9:30 a.m. and 11 a.m. If the first case booked is a minor operation, the second may be booked at 9 o'clock. We have no difficulty about favoritism. When the first hour is taken, the next doctor takes the next hour. We allow an hour for minor and an hour and a half for major operations.
2. We require a diagnosis when booking an operation. It is always graciously given.
3. Only members of the hospital's medical staff are allowed to do surgery in our hospital. We have a junior and a senior staff. A junior surgeon, *i.e.* one who has done surgery for less than three years, must have a senior surgeon as assistant.
4. A nurse is not permitted to serve as first assistant; she may be second assistant. There are no exceptions. A member of the medical staff must be first assistant.

• ALICE L. BENNETT, *Webber Hospital, Biddeford, Me.* (60 *beds*).

1. Operations are scheduled through the main office by the bookkeeper and are recorded on a pad. The first one to book a case gets the time he requests.
2. We request that a preoperative diagnosis be recorded, but no one enforces this rule.
3. Any licensed physician is welcome to operate in this hospital but a member of the staff must assist.
4. Nurses are not permitted to assist. Always, two licensed physicians perform operations.

• FRANCES M. COOPER, R.N., *Newman Memorial County Hospital, Emporia, Kans.* (64 *beds*).

1. Operations are scheduled with the surgery supervisor or, in her absence, with the superintendent of nurses. They are scheduled by doctors or by their office nurses. Major operations are scheduled on the hour beginning at 8 a.m. (occasionally earlier). The first doctor to schedule gets his choice of hours and all those who make their requests later are given the vacant hours to choose from. We never have any trouble about it.
2. Yes, we require a record of the preoperative diagnosis. The medical staff enforces the rule or takes up cases in which there is any difficulty. The surgical supervisor checks before the operation.
3. Only members of the active staff of the hospital may operate.
4. Two doctors are required for major surgery. Registered or student nurses occasionally assist with emergency appendix cases, at night or on county patients in less serious cases when the county does not provide for two doctors.

• JOHN B. FRANKLIN, *John D. Archbold Memorial Hospital, Thomasville, Ga.* (102 *beds*).

1. Operations are scheduled in the business office by the surgeon or by one of the office clerks. The first comer has his choice of time. No favoritism is practiced and there has been no friction.
2. Yes, we have a staff ruling that a preoperative diagnosis must be recorded. A word from the director of the hospital is all that is needed.
3. We have a closed staff. Each member is elected by the board and his specialty is designated. All are governed accordingly.
4. No. In an emergency the rule is waived once in a great while.

• Mary King, R.N., *Naeve Hospital, Albert Lea, Minn.* (72 *beds*).

1. Operations are scheduled in turn as they are reported to the hospital office. Friction is avoided by having the matter taken up by the staff which makes all rulings.
2. No.
3. Yes.
4. Yes, but this occurs only occasionally.

• Edna M. Lowe, R.N., *Alice Home Hospital, Lake Forest, Ill.* (42 *beds*).

1. Operations are recorded in the office. The doctor who schedules the operation first has the first time. We just do not show any favoritism.
2. We do not require that a preoperative diagnosis be recorded but we ask for it in certain cases.
3. A physician has to be licensed for surgery and must also be a member of our county medical society.
4. We do not permit a registered nurse to act as first assistant except in case of emergency. A doctor is the assistant.

• Lorraine Lucas, *Wells County Hospital, Bluffton, Ind.* (25 *beds*).

1. Operations are scheduled by consulting the superintendent. The first one to schedule is given first place. We schedule at 8 a.m., 10 a.m. and noon.
2. Yes. The superintendent enforces the rule and the doctors are most cooperative.
3. Yes.
4. We have an all graduate staff. There are no exceptions.

• Margaret A. Meek, *Culver Hospital, Crawfordsville, Ind.* (60 *beds*).

1. The operations are scheduled in the office of the hospital. This schedule is followed but, if a change is made in any case, the matter is arranged between the surgeon and the attending physician.
2. We require a preoperative diagnosis but at times this is difficult to obtain.
3. No. He must have the credentials of a surgeon, showing that he has had special training in surgery, or satisfactory evidence of surgical residency other than internship or its equivalent.
4. At times we do permit a registered nurse to act as first assistant.

• Magaret A. Mohler, R.N., *Girard General Hospital, Girard, Kans.* (15 *beds*).

1. Operations are scheduled by giving the first doctor to ask for the surgery the date and hour he requests. Succeeding operations are scheduled around that time by the supervisor. There are exceptions to this rule but ordinarily it is accepted.
2. We like to have a preoperative diagnosis; however, the rule is not enforced at the present time. We are hoping to instill a "sense of pride" in our doctors so that it will be easier for us to keep our records in the future. It is pretty hard for busy doctors to take the necessary time to complete notes.
3. The question has never come up for discussion but I suppose they can. However, to date, all of our physicians have been above reproach and would not attempt anything that they were not capable of doing. I do not know who would be responsible for placing this restriction—or why. An emergency might arise that would make any restriction seem silly and, again, it might be a good thing.
4. A registered nurse is first assistant if the surgeon requests it; undergraduates, never.

• Tressa Pierson, *Ellsworth Hospital, Ellsworth, Kans.* (35 *beds*).

1. Operations are usually scheduled by the operating room supervisor. We have only two physicians doing major surgery and they are in partnership. All of the members of our medical staff work well together and usually consult one another as to the time set for operations.
2. Yes. An operative record blank, with the patient's hospital number, name, room and physician filled in, is left in the doctors' room, which is connected with the operating room. The doctors fill out the preoperative diagnoses before they scrub up for operation.
3. I believe any licensed physician in good standing with his district and state medical associations can operate, provided one of our own staff physicians assists with the operation. There are no outside physicians doing surgery in our hospital.
4. Nurses do not act as first assistant to the doctors in the operating room. We do have a junior and a senior nurse scrubbed up to serve as sponge and instrument nurses.

• J. R. Pryor, *Mayfield Hospital, Mayfield, Ky.* (40 beds).

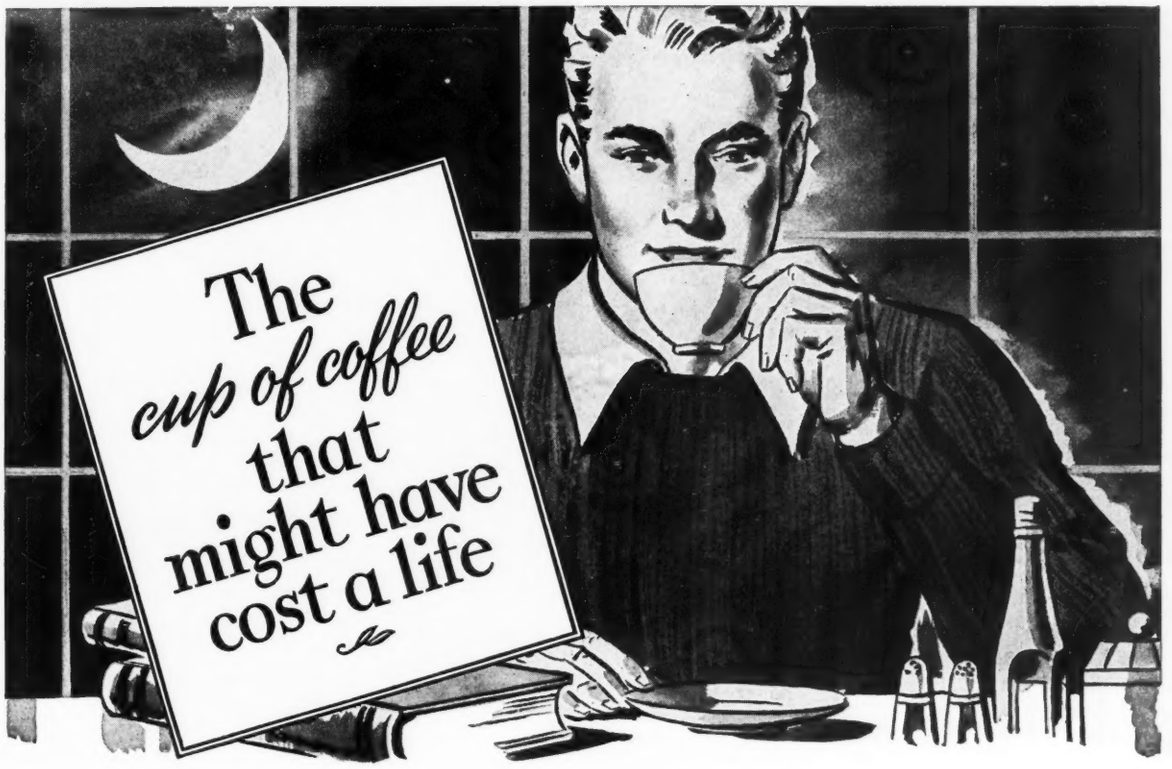
1. Operations are scheduled with the operating room nurse as the patient comes in or is booked.
2. Yes. The rule is enforced by the operating room nurse.
3. No. Our surgeons must assist them unless they are qualified as surgeons.
4. Exceptions are made occasionally. Otherwise, only doctors are allowed to assist.

• Lucine Reep, R.N., *Sheldon Memorial Hospital, Albion, Mich.* (40 *beds*).

1. We have a book in the main office in which operations are scheduled, usually by the bookkeeper. We have two operating rooms and so can allow two doctors to operate at the same time. Of course, the first two who call in are given the choice of hours for operation.
2. We require a preoperative diagnosis. Occasionally, one is not recorded but our operating room supervisor is supposed to see that this is done.
3. No. Only staff members in good standing can undertake surgery. Other physicians may bring their cases in, refer them to a staff doctor and assist at the operation.
4. We have all graduate, registered nurses on our staff. Our bylaws call for a physician for first assistant but, at times, in emergencies or when the patient is very poor the doctors insist on using a nurse as assistant. We are requiring more doctor assistants than we did for a while.

• Nancy C. Tully, *Hayswood Hospital, Maysville, Ky.* (38 *beds*).

1. Operations are scheduled in the office by the person in charge. First come, first served.
2. Yes. The surgical supervisor is responsible. We do have difficulty enforcing the rule and wish we knew of some method of making it "stick."
3. No.
4. A registered nurse is permitted to assist in simple surgery or in emergencies.



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Caring for Cardiac Patients

JOSEPH C. DOANE, M.D.

HEART disease is a comprehensive term. It is loosely employed to describe pathologic conditions of the heart muscle, the pericardium, the endocardium and, of course, the valves. Heart disease is often a chronic condition although acute inflammation of the membranes around and within the heart often precedes the chronic stage. Chronic heart ailments cannot be cured in most instances but much can be done to prolong life and to render the patient more comfortable.

The incidence of cardiac disease in the hospital census is so high that this condition presents not only an important medical problem but also an economic problem of no mean proportions. Cardiac disease is the leading cause of death in this country. Indeed, there are many who believe that coronary occlusion, often called the "doctor's disease," is markedly on the increase. (In Philadelphia during a five year period hospital deaths from coronary disease increased 150 per cent over the figure for the preceding five years.)

The treatment of this type of patient is designed to restore the balance of venous and arterial pressures and, by so doing, to maintain the normal speed of circulation. Even when this is accomplished by bed rest and by the use of digitalis, without which the cardiologist could do little, the relief of symptoms may be only temporary. Once the interchange of oxygen and carbon dioxide has been brought back to a proper level in the lungs and waste is again effectively eliminated through both lungs and kidneys, the patient may be entirely without symptoms although serious disease of the heart muscle or valve may still exist.

Many cases of heart disease arise from a previous rheumatic fever or from chorea. There is much truth in the dictum that to prevent rheumatism is to prevent heart disease. Adequate facilities must be provided for the prolonged care of children suffering with rheumatism. It is dangerous to discharge such patients within six weeks following the period of fever. In some communities, special hospitals exist for the care of rheumatic children during the convalescent period.

In the general hospital the dental service offers unusual preventive possibilities. The teeth of every child admitted to the pediatric ward should be thoroughly inspected and x-rayed when necessary. It should be impressed upon both physician and dentist that the extraction of badly infected teeth in the presence of a heart crippled by rheumatism is an exceedingly hazardous procedure. Most informed clinicians believe that streptococcus infection of the heart valve often follows the extraction of teeth in the individual with diseased heart valves. Cooperation between the staff physician and the institution's dentist, therefore, is but one of the services that the hospital owes the heart disease patient. It has even been suggested that it is not beyond the bounds of reason for the dentist to be able to recognize the presence of a heart murmur.

Hold Out-Patient Clinics

The department of cardiology should have a well-trained physician as director and should hold out-patient clinics at regular hours. Its staff should be available for consultation and advice to physicians from all other departments. The cardiologist should be a member of the major staff of the hospital. Whether or not a special cardiologic ward should be assigned to this department is open to discussion. A good internist should be capable of handling cases of heart muscle disease and, inasmuch as the medical wards contain such a large number of cardiac cases, it is probably not advisable for every patient suffering with any form of heart disease to be separated from the general medical service. Some unusual pulse irregularities, however, might be recognized more quickly by the cardiologist than by the general internist. In hospitals that have a thyroid division the surgeon assigned thereto often works well with the cardiologist.

The equipment necessary to render proper treatment should certainly include apparatus for electrocardiography and the study of circulation time. In the last two decades the galvanometer has been more and more frequently employed by clinicians in studying the condition of the heart muscle and its nerve conducting system. Because of the frequency with which thyroid and cardiac disease are associated, a basal metabolic service should prove highly useful. X-ray equipment for taking orthodiagrams or cardiac measurements is likewise a necessity. Oxygen therapy equipment is also important.

The hospital certainly owes the surgical patient a thorough study before an operation is performed. In some institutions both a consultation between the internist and cardiologist and an electrocardiograph are obligatory before any major operation.

Some general considerations are worth noting. The handling of the cardiac patient by nurses and house physicians should be characterized by the greatest tact in order to dispel the fear that often hovers about such patients. The presence of an association for the prevention and study of heart disease in a community furnishes the hospital with a strong stimulus to do better work.

It is difficult to give heart disease patients adequate care without the aid of a well-trained social service department. Little does it profit either the patient or the hospital if after many weeks of careful treatment the patient is allowed to return to work that is too arduous for his strength. A constant follow-up system and supervision of the patient's regime both at home and at his work will prolong the interval between heart breakdowns and, hence, will give him many additional years of effort and usefulness.

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Social Work Builds Good Will

FRANCES M. MONEY

No one is in a better position to convert critics of the hospital into friends than the social worker. Miss Money points out some of the ways in which the social worker can be of service to the public

PERHAPS no integral part of the hospital has more contact with the public than does the social service department whose chief function embraces the study of the individual patient's social situation, interests and needs in relation to his illness.

The medical social worker has three important points of contact. The first is the patient himself; the second is the physician, and the third is the social agency in the patient's community.

Everyone who reads a newspaper and so may be influenced by what the press says about the hospital is a part of the hospital's public. Besides the newspaper reader, there is the patient. His report of the hospital may be far reaching. It is quite likely that everyone who knows him will know what he thinks of the institution.

In addition to the press and the patient, there are certain segments of the public with which the hospital has frequent contact. We are concerned here with those who most often request information and service through the social service department in behalf of their patients or clients or upon whom the social worker most frequently calls to assist in the care of individual patients. These fall into two large groups.

The first consists of the formally organized public and private social and health agencies in the area from which the hospital draws its patients. When one considers not only the staffs of these institutional and non-institutional social and health agencies but the board members and public officials who sponsor their work, this is a sizable group and, on the whole, an articulate one.

The second category includes the informal voluntary groups made up of secret societies, women's clubs and church organizations. These groups are often large in membership, although somewhat limited in funds, and frequently have members under hospital care. When called upon, they usually contribute valuable social information and often are able to assist in carrying out medical recommendations by paying for orthopedic apparatus, glasses, convalescent care or some other need. Furthermore, they may be instrumental in furnishing suitable employment.

The schools deserve special mention since they are often the chief community agency in assisting the pediatric patient.

Social administration offers some of the same opportunities for helping the patient accept his treatment regimen and the hospital's routine as those presented in the more intensive case work group. The social worker who as a matter of established policy interviews every new cardiac, diabetic or syphilitic patient participates daily in a great deal of interpretation, which will spare the patient fear or anxiety concerning the regimen he is to follow. These early interviews also prevent the patient's criticism of the routine the hospital has set up to serve him to the best advantage because he is given an opportunity to ask questions; some of his unformulated questions are answered, too. Thus, he learns at the outset why a certain amount of time is required for certain procedures and what his own part is in enabling the doctors to help him.

If the hospital has a medical social admission system or if it requires a social review of all ward patients upon discharge, there are parallel opportunities to explain necessary hospital procedures and the hospital's place in the community along with other institutions better equipped to supplement certain phases of his care. In this way the chronic disease patient is not discharged to criticize the hospital perpetually because it failed to "cure" him or was "not interested" in him.

A patient group that has been well served has a convincing message to the public and, insofar as the medical social worker has some small share in the care of patients, she has a proportionate responsibility in developing favorable public opinion regarding the hospital.

The social and health agencies working with the hospital become conversant with its policies and practices through teamwork on individual cases. But policies change and conferences are necessary from time to time so that the reasons for changes are understood and accepted. Either the hospital administrator should be present at such meetings or his point of view should be well presented by the social service department.

The social organizations in the community which are not formally organized to function on a professional social work level but which, nevertheless, are often the best sources of supplementary care for the patient often want someone to talk to their members concerning the hospital. The request may come to the social service department because it has worked with the group in relation to certain patients. Whether the social service department or the superintendent of the hospital should address them depends upon the composition of the group and what they really want to know. The important thing is the opportunity that these organizations offer for interpreting the hospital to the community. It is well to bear in mind when arranging one's remarks that there will probably be at least one former patient in the audience.

Miss Money is director of the social service department, University of Minnesota Hospitals, Minneapolis.

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Preparing the Report

LEROY P. COX

MOST trustees look at hospital reports to see how much loss has been incurred and their interest ends there. A few study them and these few make a superintendent believe his work on the report is worth while.

The indications are that a large section of the general public does not read these annual reports. However, there is a value to these reports that cannot be appraised and this is the effect on prospective donors. Persons who are interested enough in a hospital to authorize a bequest will read the reports.

Some persons, if they are interested enough in a report, will make a gift or a bequest. Most persons are interested in pictures and graphs. In financial figures the totals are what catch the eye. Explanatory text is read because that is more or less in letter form and most of us like to read letters.

Monthly reports, which are generally seen by the trustee only, should be as brief as possible and still give all pertinent facts. They should be typed on a good grade of onionskin paper so that carbon copies can be made. All copies should be clear, care being taken not to make too many at each typing. If they are to be delivered by hand, a cover of lightweight kraft paper or heavy bond should be used on which the contents and the month are printed or typewritten. If the report is mailed, a cover is unnecessary. This will save postage.

Variations of the following suggestions can be made to apply to any particular hospital. Four divisions of figures are recommended. On the first sheet in condensed form should be shown the income and expense totals on an accrual basis. On the same sheet and below the accrual basis figures should be shown results on a cash basis. The latter set of figures is not desirable from an accountant's standpoint but to many trustees it is of much interest. The expenses shown in the cash basis figures are generally the entered expenses for the month under review. In theory, and it can be done in practice, the actual expenditures for the month could be shown. The facts are quite distorted when actual expenditures are given because the expenses incurred for items already received which have been given or rendered to patients and for which some cash has been received are not considered. For these reasons, the month's entered expense figure should be used.

The third division of figures is a detail of income, these being accrued figures. The fourth division shows a detail of expense as incurred for the month. The expense figures are given by departments and in any detail desired.

On all the sheets, four columns of figures should be shown except for the first month of the fiscal year which would need no "to date" columns. On the first sheet, which shows the condensed figures on accrual and cash bases, the columns should be headed, for example, "August 1939," "August 1940," "To date 1939" and "To date 1940." The columns can be headed in the same way for the detailed income and expense figures. Budget figures for the month and "to date" shown for income and expense are preferable to figures for the previous year.

Some place, probably on the first sheet, the number of patient days, average number of patients per day and the per capita cost should be shown for the month and "to date" as compared with month and "to date" for preceding year. The accounts payable figure for the current month should be compared with previous month and any increase or decrease should be noted. Any other figures can be set up as desired. Try to keep the report down to details in which the trustees are really interested. If too many details are included there is less chance of the report's being read.

The first section on the first sheet should show information somewhat as follows:

Income earned	**$0,000.00**
Less: Free work	**000.00**
Discounts for cash	**000.00**
Anticipated bad debts	**000.00**
Net income expected from patients	**$0,000.00**
Entered expenses	**0,000.00**
Gross deficit	**$ 000.00**
Received from endowments	**000.00**
Received from city and state	**000.00**
Received from community fund	**000.00**
Net loss or (gain) accrual basis	**$ 000.00**

The second section on the first sheet showing figures on a cash basis could read as follows:

Cash Received From Patients:	
Accounts since 1/1/40	**$0,000.00**
1/1/39 to 12/31/39 (or 1939)	**000.00**
1/1/38 to 12/31/38 (or 1938)	**000.00**
1/1/37 to 12/31/37 (or 1937)	**00.00**
Prior accounts	**000.00**
Recovery from bad debts	**00.00**
Auxiliary departments	**000.00**
Miscellaneous	**000.00**
Total	**$0,000.00**
Less: Discounts	**000.00**
Net hospital income	**$0,000.00**
Entered expenses	**$0,000.00**
Gross hospital deficit	**$ 000.00**
Received from treasurer	**$ 000.00**
Net loss or (gain) cash basis	**$ 000.00**

Bequests, endowments and large gifts should not appear in the first

The author is superintendent, Woonsocket Hospital, Woonsocket, R. I.

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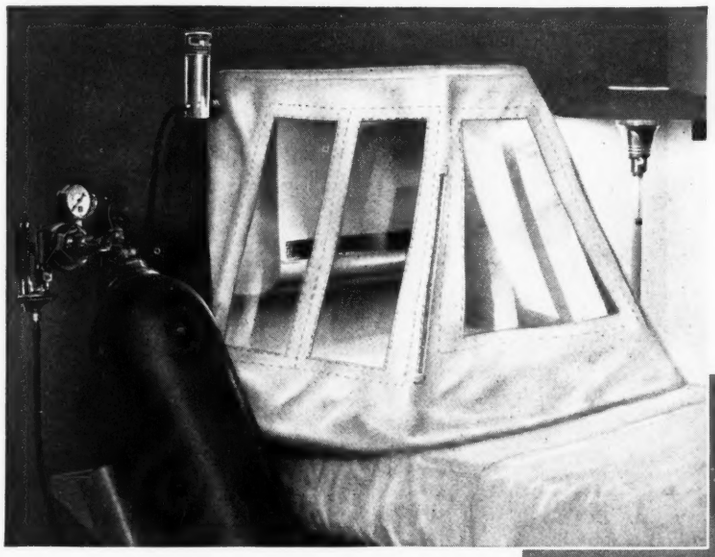

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set of figures or the comparisons will be out of line. They can be mentioned as footnotes. Income from endowments should be included in the figures shown.

The figures given in the report for the last month of the fiscal year can be used in the annual report. There should also be a balance sheet, which the auditor can make. In a small town the local banker or someone who knows bookkeeping can make an audit for the hospital. No matter what the size of the hospital may be, annual audits should be made by competent persons.

The annual report should list all the officers of the hospital and the doctors by their specialties or by groups, such as consulting or courtesy. Next should come the names of working staff department heads. Following this, there should be letters by the president, chief of staff, superintendent, head nurse, laboratory director, roentgenologist and others as desired. Some figures can be shown in these letters but, as a rule, these should be limited and inclusive. The balance sheet, income and expense and other financial figures come next, followed by vital statistics. The space devoted in some reports to classes of sickness and operations is of iittle interest to anyone but the doctors.

A special section should list the officers and members of the ladies' aid society. A letter written by the president of the aid stating its accomplishments and other facts is always interesting. The ladies' aid does so much for most hospitals that this recognition of its work should be made.

Somewhere in the annual report there should be a form stating how a bequest can be worded. This has proved to be fruitful. Suggestions regarding the hospital's needs, possibly showing the purchase price, will often lead to someone's supplying a required item.

Annual reports can be made inexpensively by using a mimeograph. A few hospitals have their annual report or yearbook financed by advertisements, although this plan is not favored.

Boards of trustees should authorize annual reports so that the public can have accurate information. The expense may seem unwarranted but is really so small per capita that the public relations value alone is worth more than the cost.

Keep the Public Informed

L. A. CHAMBLISS

NO MATTER how extensive its private operations, every hospital is in part dependent upon the good will of the general public for its success in operation. It is, therefore, incumbent upon the institution to keep the public appraised as to the nature and quality of its service.

One of the best means of accomplishing this is through the distribution of a home magazine, such as "The Message," which is printed and distributed without charge to a large mailing list by the Hospital of St. Barnabas and for Women and Children in Newark, N. J. This little publication goes periodically to more than 4000 individuals and to 50 churches. In addition, 300 doctors are given 25 copies of each issue for office distribution. In all, some 15,000 persons are thus regularly afforded the opportunity to know what is going on at the Hospital of St. Barnabas and how the institution is being managed.

In addition to its own publication, the hospital has been singularly successful in obtaining cooperation from the public press. The local Newark newspapers use many pictures and columns of reading matter annually in helping spread the gospel of good service as preached by St. Barnabas. It is easy to preach this gospel, for the service to human kind in repair of human ills is one that always commands attention.

An example of newspaper cooperation was the large amount of space given to the dedication of the new south wing in 1938, at which time the Newark and suburban daily and weekly newspapers published a total of 57 pictures of the building and activities within it, as well as stories concerning the event. Professional journals, such as The MODERN HOSPITAL, are not overlooked. Articles concerning the different phases of hospital activity are published in them from time to time. These journals are always willing to publish items of interest to other institutions throughout the field.

The matter of public relations, however, goes far beyond that of obtaining printed publicity, valuable as it may be. "The Message" and the cooperation of newspapers and other publications are of prime importance in building public favor, but the real job in public relations is to "meet the public" in a spirit consistent with quality service.

To this end, the hospital administrator and his aids, upon invitation, visit church congregations and meetings of other organizations to tell of the hospital's activities and facilities for serving the community and its people. Not only the official staff members but also others who are interested in the institution's welfare grasp opportunities to spread the word. By this method there is direct personal contact with hundreds of individuals who one day may be served by or may serve the hospital organization.

St. Barnabas maintains a guild, an auxiliary and a junior guild. These groups are comprised of persons who are interested in assisting in the work of the hospital. These agencies gracefully promote public relations and develop favorable understanding.

One operation of the guild organization, for example, is the maintenance of a tea room and gift shop in the hospital building. It is called "The Open Door," and is conducted by two employed workers with the help of volunteers. Among the volunteers are a group of girls of high school age and members of a junior Red Cross group.

Another public relations service that has been developed recently and is an excellent means of improving public relations is supplied by a group of volunteer hostesses who assist the hospital's full-time hostesses in directing and aiding visitors on the various floors and in the wards. This volunteer service, which is carried on afternoons and evenings during regular visiting hours, is expected to yield still further dividends as a paying contact with the public.

Mr. Chambliss is secretary of the Hospital of St. Barnabas and for Women and Children, Newark, N. J.

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Transporting Medical Records

ADALINE HAYDEN

AN EFFICIENT record department is one in which all legitimate requests can be answered without delay. In order to answer these requests a satisfactory system of transportation is required. There are three such systems of transportation now in use in hospitals, *i.e.* messengers, carriers and pneumatic tubes.

All who have used messengers are aware of the expense involved because of the amount of time consumed and because of the difficulty of having enough available at the time of peak loads and not too many at other times. If only a minimum of messengers is employed in order to keep costs at the lowest level, the service is likely to be unsatisfactory. Some hospitals that have found messenger service uneconomical and inconvenient have tried the simplest form of mechanical carrier, the hand operated overhead trolley; others have installed a mechanically operated endless chain upon which baskets are carried.

By far the most practical and useful of the three systems is the pneumatic tube system. By using it, each clinic and hospital floor can be served without delay.

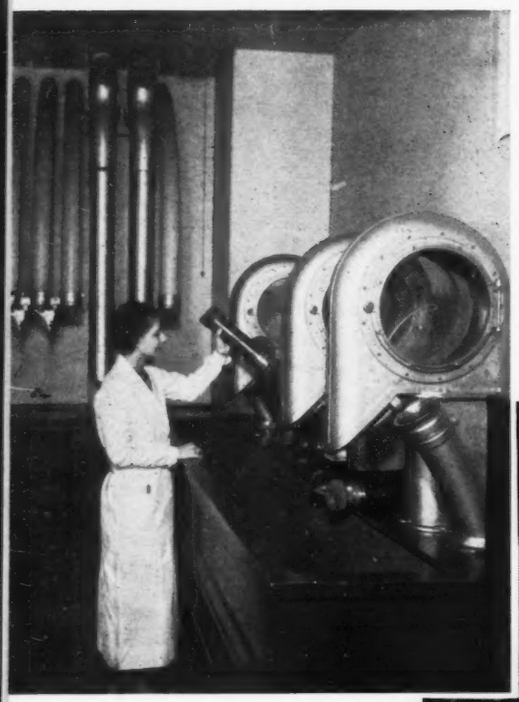
The University of Chicago Clinics has a central record room with the unit system of record keeping. A pneumatic tube system is in use that serves the out-patient department and the four hospitals in the group. The main station for the pneumatic tubes is on the first floor of the central record library. It is necessary to employ only one girl to operate the 38 sending and receiving lines connecting each clinic and floor in three of the hospitals; the fourth hospital (Chicago Lying-in) is served by a substation connected by tube to the central station. It is not at all unusual for material to be transported from one extreme point in the hospital to another, the maximum distance being three blocks.

Each line is numbered. The carriers are 14 inches long and 3 inches in diameter, so that patients' records of ordinary size can be inserted. Each carrier has an indicator, which makes it possible for anyone to send material to the central station to be relayed to another station.

Some people object to the rolling of the records; if a kraft paper is used as an outside cover, however, the rolling is not detrimental as the charts are in the carriers only a few seconds.

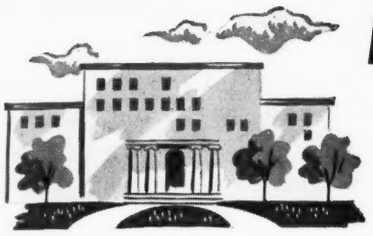
There are direct receiving and sending lines to the substation on the main floor of the Lying-in Hospital, approximately one block from the central station. These lines run underground. There are 10 lines from the substation to the clinics and floors in the Lying-in Hospital.

Blowers that deliver air to every line are used to operate the system in both hospitals. When the carrier is dropped into the line and the handle is pushed down, air is permitted to enter the diaphragm chamber. The diaphragm, in turn, opens the valve that admits air, thus forcing the tube on its way. The motors that drive the blowers on the central and substations are 18 and 15 h.p., respectively.



The pneumatic tube system installed at the University of Chicago Clinics has solved the messenger service problem. The picture above shows the substation located in the Lying-in Hospital. At the right, a nurse at one of the floor stations sends a request by tube to the main station.

The author is record librarian at the University of Chicago Clinics.



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The cost of installing the whole system was $35,000. The operating cost is approximately 12 cents per hour for each station, or $2 a day. From the financial viewpoint the cost is justifiable. It is estimated that the pneumatic tube system saves the salaries of 10 messengers, as it would require at least that many to transport the volume of material that is handled daily. (Material sent through the tubes includes not only medical records but forms and correspondence from such other offices as the business office, cashier, laboratories and pharmacy.) Messengers cannot be obtained for less than $15 a week, which would mean a weekly cost of $150, or about $6 per clinic day, and supervision would have to be provided.

Besides the direct cost for messengers, the amount of time saved and the convenience should be considered. It is not at all unusual for from 20 to 30 requests to come to the record department as fast as the carriers can travel through the lines, each request calling for a record needed for a patient awaiting treatment. The extra telephone load would be considerable and more mistakes occur if each clinic or floor has to telephone requests to the messenger station.

The pneumatic tube system is used only for the records of patients who come in without previous appointment. Records for patients with appointments are taken up to each clinic the first thing in the morning by the clerks in the respective clinics. Sometimes 150 or 200 requests a day come from 18 clinics, doctors' offices, hospital floors and service departments in any of the four hospitals.

The tube system has solved one of our major problems and has proved most satisfactory, offering a prompt and efficient service.

How to Handle Anthracite

RUEL E. DANIELS

A MATERIAL saving in fuel costs and boiler maintenance may result from an understanding of the theories of combustion and an earnest endeavor on the part of engineers to make a practical application of these theories. In firing a boiler, gases omitted from the coal after it has been heated are being burned. These gases combined with oxygen produce carbon dioxide which, when ignited, produces the heat units.

Eighty-five per cent of the difficulty in burning fuel is directly attributable to improper draft controls or to an improper use of draft controls. A simple explanation of draft is that heavier air has a tendency to displace lighter air. Nature strives to place gases in their proper position relative to their weights. Air is heavier than combustible gases and, therefore, will have a tendency to displace them, forcing them up the chimney. The hotter a gas, the more it expands and the lighter it becomes. Air at 40° F. is twice as heavy as air at 400° F. Gases from anthracite coal ignite at 925°. The heavy cool air will cause a draft by forcing the hot air up the chimney. This flow of air may be regulated by a stack damper or a check damper. The stack damper located in the smoke pipe is usually manual. The check damper is either manual or connected to a steam diaphragm. These two dampers are important to control draft and facilitate combustion.

The opening of the check damper will retard the draft because it cools the combustible gases rising through the chimney and thereby increases their weights, offsetting the difference in weight of the hot gas and the cool air passing through the draft door. There is no necessity for closing the draft door if the check draft is opened. The draft is thereby checked and the combustible fuel gases are retained in the boiler giving off heat units. They are not lost up the chimney. By the same token the feed door should never be left open to check the draft. This cools the inside of the boiler. A boiler can be checked more efficiently and more economically by use of the check draft.

Normally the stack damper should be operated two thirds closed. This position may have to be varied. Careful observation will determine the correct position.

Clinkers are formed because of too little air and not too much air. Also, clinkers are not in the majority of cases caused by inferior coal. A fire must breathe and if insufficient oxygen is fed to the burning coal the fire will collapse, forming clinkers. If additional oxygen or air is forced through a fire it is possible to burn clinkers. Always make sure to have an abundance of fresh air in a boiler room. You cannot expect to feed oxygen to a fire if the boiler room is deficient in air supply.

With the blower system it is often better to run ordinary galvanized smoke pipe from outside to the intake of the blowers. This will aid in combustion and consequent fuel reduction. The intake of a fan or blower may be controlled. Never reduce the output. That would give greater force to the air being sent into the fire. The air would travel to the rear of the ash pit, giving unequal distribution of air to the fire bed. However, it is sometimes necessary to reduce the intake in order to obtain more even combustion.

Chimney flues and breechings should always be free from soot. A novel method of cleaning a stack is to discharge a blank cartridge in the base of the stack.

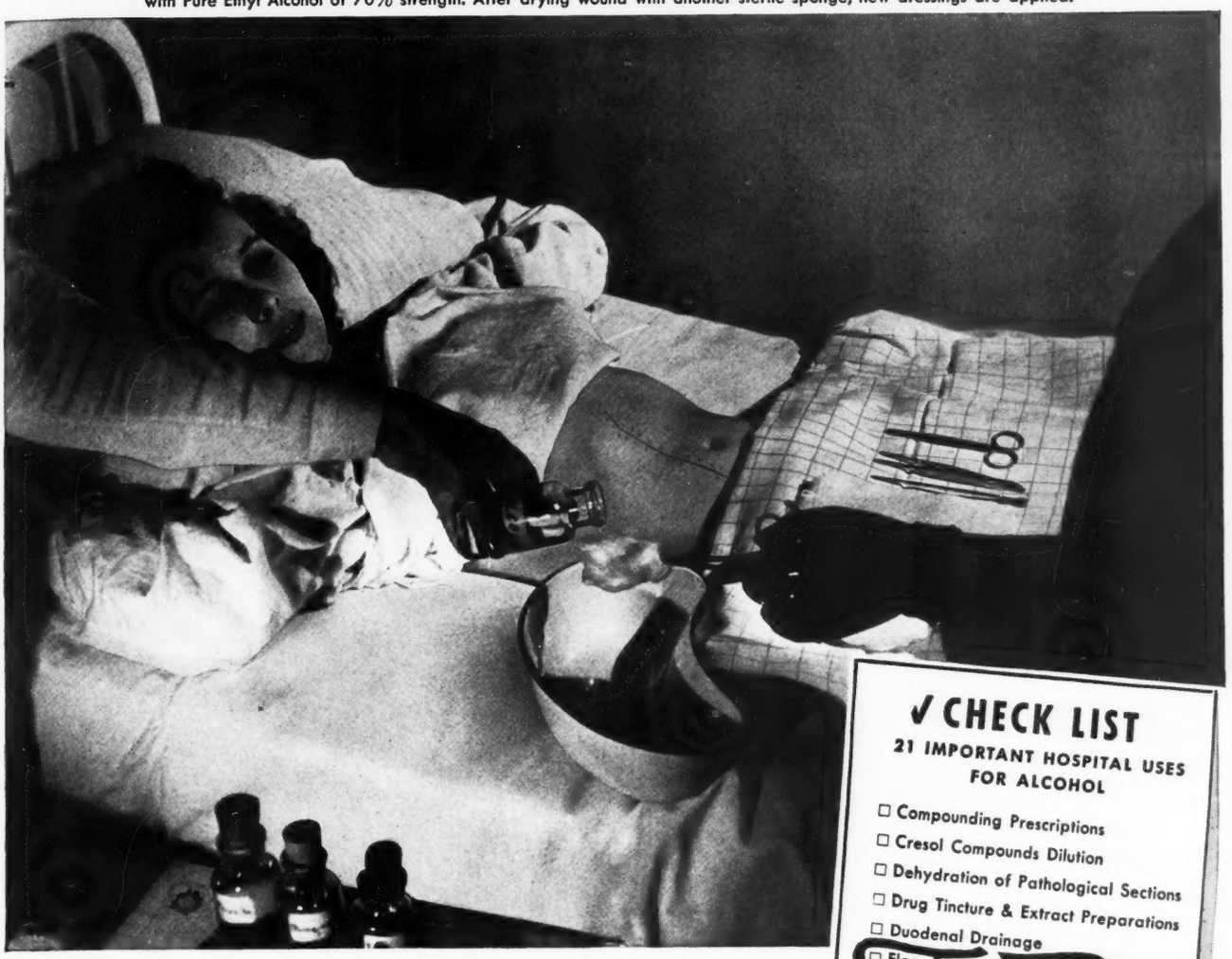
The draft doors should be open when the blower is not in use. This ensures a sufficient supply of free oxygen in the ash pit. Water in the ash pit will also aid combustion. It will not warp the grates.

Green coal should never be thrown on a fire immediately after it has been cleaned. The fire should be forced to a higher temperature so that the green coal will ignite as soon as it comes in contact with the fire.

Try to operate the heating unit in such a way that there are constant heat and even temperatures. Constant heat may be obtained by keeping a thin fire and firing frequently. Even temperatures result and a lower fuel consumption is obtained.

The author is district clerk and business manager, board of education, Belleville, N. J.

After the removal of adhesive, bandage and dressing, the wound or incision is cleaned with a sterile sponge saturated with Pure Ethyl Alcohol of 70% strength. After drying wound with another sterile sponge, new dressings are applied.



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Devised to Prevent Gas-Mix Ups

JOHN S. LUNDY, M.D., and

THOMAS H. SELDON, M.D.

IN order to eliminate the danger of attaching a tank of gas, such as carbon dioxide, to the yoke reserved for one of the anesthetic gases or oxygen, a special arrangement has been used for several years at the Mayo Clinic. The strainer nipple in the oxygen yoke of each gas machine has been enlarged, and the port in the valve of the oxygen cylinder, into which the strainer nipple is placed, has been correspondingly enlarged. The airtight fit is accomplished by forcing the face of the valve up against the lead washer, which is held in place by the strainer nipple against the face of the yoke (fig. 1). This arrangement allows the oxygen cylinder to be used on any hanger yoke but, in the gas machines at the clinic, effectively precludes the placing of a cylinder of nitrous oxide or other anesthetic gas on the oxygen side of the machine with the possibility of resulting disaster. The cylinders for oxygen are built so that they are still adaptable to other types of oxygen yokes and can be used if they are sent to some institution that does not have this especially arranged yoke.

The arrangement of the carbon dioxide yoke has been changed by removing the strainer nipple from the yoke and inserting it into the port in the valve of the cylinder of carbon dioxide. Just as there is a lead washer on the oxygen cylinder and yoke, so we have a lead washer to make an airtight fit when the face of the valve is forced against the lead washer and yoke (fig. 2). This device makes it impossible to hang any cylinder in the carbon dioxide yoke except one in which the nipple is inserted into the face of its valve and also makes it impossible to hang a cylinder of carbon dioxide on any but the carbon dioxide yoke of the gas machine.

Inasmuch as the anesthetic gases are most carefully supervised, no alterations have been made in the yokes of the tanks of the three gases most commonly used: nitrous oxide, ethylene and cyclopropane. It is not our practice to keep the cylinders of gases that are used only occasionally in their yokes on the anesthetic gas machines. When a special agent, such as cyclopropane, is specifically indicated, the cylinder containing it is attached just before it is used.

The authors are associated with the section on anesthesia, Mayo Clinic, Rochester, Minn.

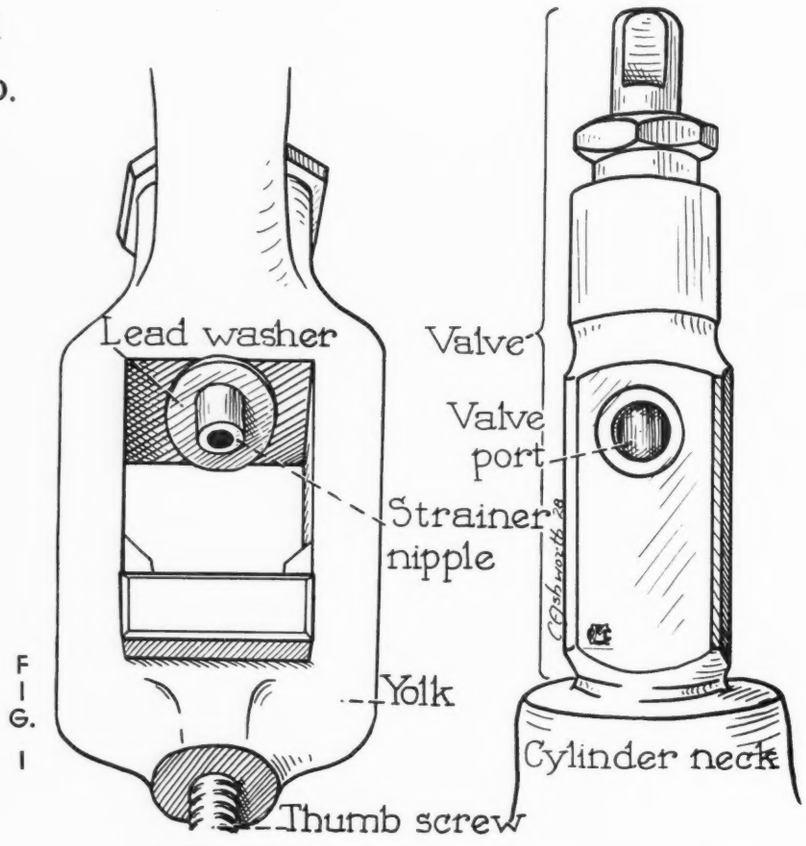


FIG. 1

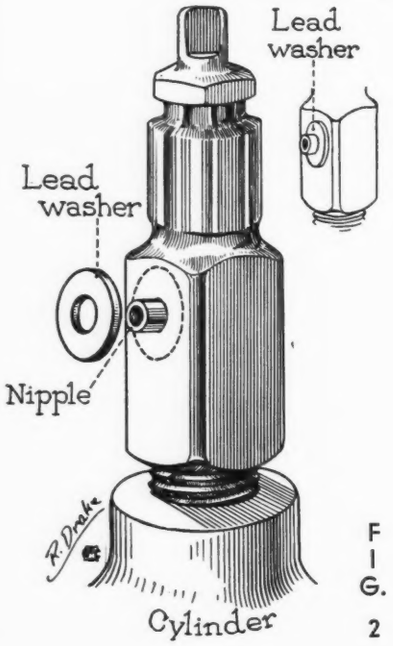
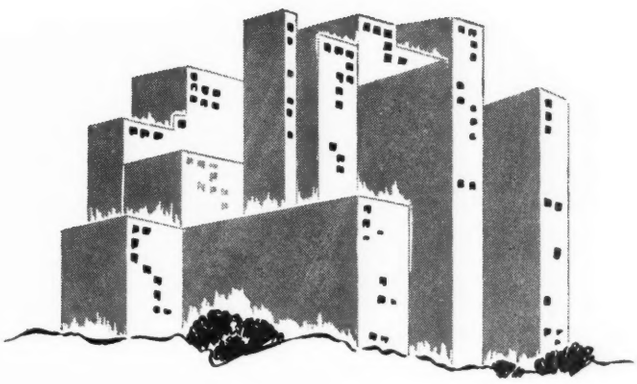


FIG. 2

Fig. 1.—Strainer nipple in yoke of gas machine and port in valve of cylinder. The port in the valve of the oxygen cylinder is enlarged 0.4 mm. The corresponding strainer nipple is also enlarged 0.4 mm.; no other cylinder will fit.

Fig. 2.—Special outlet for carbon dioxide which prevents cylinders containing carbon dioxide from being placed on the wrong yoke in the gas machines. The nipple is removed from the gas machine and incorporated in the valve of the cylinder; the lead washer is then slipped over the nipple and the tank is easily put in place. The dotted line indicates the bearing surface of the lead washer surrounding the nipple. The inset shows the washer on the nipple.



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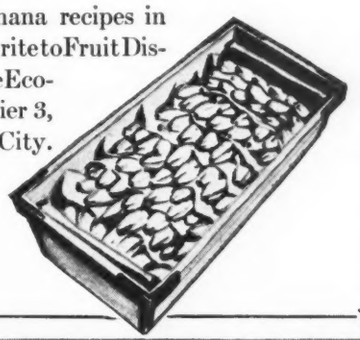
If you haven't tried boxed bananas yet, why not specify them when placing your next order? When you receive your bananas, place them in a room with a comfortable temperature (65 to 70° F.) and let them ripen completely until the golden peel is flecked with brown and the pulp is mellow.

Today bananas are used by hospitals and institutions in numerous special diets and served in many tempting ways. This bland, nourishing fruit, well-liked by most people, contains vitamins A, B_1, C and G as well as many important minerals. It thus helps protect against deficiency in the diet.

For free tested Banana recipes in quantity proportions, write to Fruit Dispatch Company, Home Economics Department, Pier 3, North River, New York City.



Include BANANAS on your menus regularly for both Patients and Personnel { **Few foods give so much value for your money!**

Safe Dishwashing Technics

WALTER D. TIEDEMAN

STUDIES of dishwashing methods and of so-called sterilizing or disinfecting processes have led us at the New York State Department of Health to the conclusion that good washing and rinsing are fully as important as disinfection. Effective scraping or prerinsing of the dishes makes it easier to maintain an effective concentration of detergent in the wash water. Some methods of disinfection fail if any greasy film remains on the utensils after washing. Conversely, surprisingly good results have been obtained by washing in clean water, using a good free rinsing detergent, followed by a copious rinsing in clean water that is preferably, but not necessarily, hot.

Of course for safety, particularly in treating dishes in hospitals, subsequent disinfection is essential and for this purpose it is our opinion that nothing quite equals immersion in hot water thermostatically maintained at a temperature of 170° F. or higher. Dishes so treated dry quickly without toweling, which is an important consideration.

What Is a Good Detergent?

The practical application of these principles to dishwashing on a large scale, such as in a hospital of average size, deserves considerable thought. One of the first questions that arises is: what is a good detergent?

It is to be expected that the detergent or washing compound will (1) emulsify food fats, (2) flocculate other food solids, (3) wet glass, china and metal surfaces readily, (4) suspend calcium or other minerals in the water and (5) rinse freely. A good detergent has these important properties. Of course, some are better than others. As regulatory officials we must avoid giving one manufacturer an advantage over another. However, we realize the pressing need of the average buyer of detergents for some definite information on the subject.

The answer to this problem, we believe, is to classify detergents by a standardized test on the basis of their power to remove from previously cleaned glass slides a fixed quantity of a standard soiling material in a fixed time by mechanical washing without leaving a film on the glass. If any film remains it can be evaluated by an arbitrary scale reading using the electric eye to detect the amount of light from a fixed standard source passing through the slide.

Our laboratory* is undertaking such tests at different temperatures under average hard water conditions for New York State. The intention is to test all detergents which, according to formula, should have satisfactory cleansing properties that are submitted to us and to divide them into three classes based upon the results of the tests.

Eventually a classified list may be published. The classification will also indicate the detergents that are satisfactory for machine washing and those that are suitable for hand washing. To guard against the fraudulent submission of samples or the dropping of standards after the test has been made, it may be necessary to strike any product off the list if commercial samples at a later date fail to measure up to the standard of the samples submitted for test.

The temperature and hardness of the water play important parts in effective washing. Some detergents that are not at all satisfactory in hard water give good results in soft water. Some detergents work better in warm water than in hot, while the reverse is true of other compounds. Furthermore, some compounds are suitable for machine washing only because they contain alkali that injures the hands. In general, detergents that contain soaps are not suitable for pressure spray machine washing because of excessive foaming.

Many ordinances require a period of two minutes for immersion or spraying with hot water as a disinfecting treatment. With few exceptions the commercial machines on the market are not built to this specification. Time saving is an important element in commercial operation. Our tests indicate that rinsing for 30 seconds is sufficient, with good washing and the use of ample volumes of thermostatically controlled rinse water. In spray washers the volume and distribution of the hot water that reaches each utensil are more important factors than the length of time the spray is applied.

Maintaining High Temperature

The ordinary hot water system cannot be relied upon to deliver adequate volumes of water at 170°F. for rinsing dishes. A common and simple way to maintain water at or above this temperature for rinsing purposes by submersion is to install a gas burner under a sheet metal tank of water. The temperature can be thermostatically controlled at relatively low cost. Special booster heaters also are available for supplying water at 108°F. for machine rinsing. These should be purchased on a performance basis.

Properly designed wire baskets are essential for the immersion of utensils in hot water, as well as for the storage of glasses and cups. When immersing glasses and cups it is important that they be in such positions that no air will be trapped in them thus preventing the hot water from coming in contact with all of the inner surfaces. The glasses should be placed upside down in the rack and the cups with the handles up so that they can be grasped by the bottoms or handles instead of by the rims,

The author is in the New York State Department of Health.

*This work is being done under the supervision of F. W. Gilcreas, division of laboratories and research, New York State Department of Health, Albany, N. Y.

thus preventing finger contamination of the surfaces with which the mouth or beverages come in contact. A sufficient number of wire racks should be provided to store glasses and cups until they are used.

As a general rule, washing by machine is satisfactory. However, our work has revealed numerous instances in which as a result of poor design, unsatisfactory maintenance, careless operation or the use of an inadequate detergent the results have been unsatisfactory.

High bacteria counts after machine washing have been commonest in cups and spoons. The cause is probably that it is common practice to place these articles in the trays or baskets in such position that the sprays do not strike all of the inner surfaces. Furthermore, there is a pronounced tendency for operators to throw the silverware into trays in deep masses without any thought as to whether or not all the pieces will be exposed to the wash and rinse sprays.

As an example of just how careless operators can be, we observed a washing machine operator in a large store with restaurant service put two racks of glasses one on top of the other into the machine at the same time. The glasses in the lower rack almost completely prevented any of the wash water and rinse sprays from entering the glasses in the upper rack which, in turn, shielded the outside bottoms of the glasses in the lower rack.

For these and other important reasons it is not sufficient to judge the efficiency of washing and disinfecting operations by a physical inspection of the equipment and its operation. A test of the results obtained in actual practice is the only reliable criterion.

The first consideration is for physical cleanliness. Careful examination by eye will reveal pronounced films. A simple device makes it possible to examine the rims of glasses under a slight magnification with the effect of a dark field that shows up slight marks, such as finger prints. Tests have shown that the presence of any visible film does not necessarily mean the presence of bacteria but most people will admit that they prefer to have this film removed.

If the glasses pass the test for physical cleanliness, *i.e.* freedom from film, then a test for bacteria is in order. A number of tests have been proposed but the one that is most commonly accepted at present is the so-called rinse test tentatively suggested for use by the American Public Health Association. Properly washed and disinfected dishes and glasses should also be free from organisms of the colon group and from streptococci, and tests may be made for these. The New York State sanitary code now sets a standard of not more than 100 bacteria per utensil for the area required to be tested and freedom from organisms of the colon group.

Regardless of equipment or methods in use it is advisable occasionally to determine by test that clean and practically sterile dishes and glasses are being obtained. Unless the prescribed procedure for accomplishing this result is made easy there can be no assurance that it will be followed regularly by the employes.

Food Service at Gloucester House

AILEEN E. MORRISON

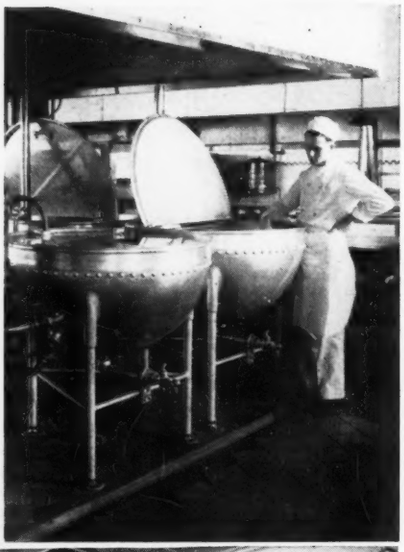
THE opening of the food service department of Gloucester House, at the Royal Prince Alfred Hospital, Sydney, Australia, must have been filled with incident and humor. Nurses, acting as patients, were put to bed and had meals served to them to enable the nursing staff to practice speedy and accurate service. Gloucester House caters to private and intermediate patients only. The cooked food, then, as now, was sent to Gloucester House in electrically heated trolleys direct from the main kitchen. During the first few days, attention was paid to the spoilage and loss of heat during standing periods. Within a week, orders could be made out fairly accurately for the quantity of food required, while times of cooking and standing were judged from the time the trays left the central servery until they entered the patients' bedrooms.

From such a beginning grew the meal service until at the present time more than 2500 meals per week are prepared and served. The dietitian's duties now include the supervision of the quantity and quality of foods purchased, preparation and service of food, menu planning, waste checking and visiting the patients. Food costs are approximated in the department and calculated accurately by the hospital accountant's office staff in order to estimate per capita costs. The foods department then checks these costs for correct apportioning of money on each food group essential in an adequate dietary.

Menus are planned in a series of 100 or more menu cards that are altered weekly according to the available fruits and vegetables. A week's series, carefully chosen to give variety and to include seasonal foodstuffs, is collected two weeks ahead. The menu card for the following day is given to the patient with the breakfast tray and those who are well enough mark off their choices for the next day's meals. This arrangement makes it possible to furnish the cooks with accurate information regarding the foods to be prepared in advance. When a patient is not well enough to be interested in his menu card, the dietitian tries to anticipate his desires for the next day without bothering him. Most patients are extremely interested in their choices, regarding them as fun.

The dietitian visits each patient daily to collect the menu cards, to help and advise choices, to discuss the type of food suitable for the individual and to try to acquire a knowledge of the patients' likes and dislikes. Any incorrect eating habits are explained to the patients, such as lack of vegetables, too many sweets or insufficient milk, but the

Miss Morrison is dietitian, Prince Henry Hospital, Little Bay, New South Wales, Australia, and was formerly at the Royal Prince Alfred Hospital, Sydney, New South Wales.



Below: The Gloucester House sweets and salads cook presides over her work unit. Part of the battery of electric food conveyors used to transport the trays is shown at the left. Right: Two of the new aluminum steam-jacketed kettles that have been installed recently. All of the old cast iron kettles are gradually being replaced with this type equipment.

dietitian's worst nightmares are overanxious mothers and wives and patients with their own definite eating habits, solidified through years of home practice.

"I never mix the proteins and starches," or "he has never had green vegetables, he wants ice cream" and "salads in winter—Oh, no!" are not sweet music to the ear and call for all the dietitian's patience and powers of persuasion.

The dietary stenographer summarizes the orders that she lists for the Gloucester House cooks and the special diets' cook. From these lists, daily milk, cream, butter, bacon and egg orders are made out by the dietitian, as are the daily fruit and vegetable orders included in the main hospital order for the market buyer. Grocery orders are compiled three times weekly; meat, fish and poultry are ordered daily as required. Any special food orders are brought as speedily as possible through the main hospital store.

The Gloucester House kitchen staff includes a meats' cook and a sweets' and salads' cook, each with her own maid, while the special diets' cook and vegetable preparer are shared with the main hospital. All cooking save that of eggs is done in the hospital kitchens.

The food is served into hot and cold dishes and placed in partially heated and insulated trolleys to be wheeled through lifts and passages to Gloucester House. The cold section holds salads, sweets and fruits.

Each food is apportioned into servings for the five floors so that on arrival at Gloucester House the containers can be sent immediately to the floors where they are put in heated steam tables in each servery. The food is checked and tasted for quality by the dietitian in the main kitchen and again is checked for quantity in the central servery.

On each floor the maids set up trays complete with patient's menu card. The nurses carry the trays to the patients.

All garbage from foodstuffs is weighed at intervals and the percentage of waste is calculated. In the event that large amounts of any one food are left uneaten a reason is sought. If the investigation proves that poor cooking is the cause, everything possible is done to improve it; if the dish suffers from sheer unpopularity, it is not repeated.

No money or effort is spared to provide high quality foods for Gloucester House. Each item checked into the dietary department is inspected by a dietitian and chef before it is accepted.

Classifications of Foods

Dietitians who have been using the classification of fruits and vegetables as published in the *Journal of the American Dietetic Association* should note the corrections included in the new circular, "Proximate Composition of American Food Materials," by Charlotte Chatfield and Georgian Adams of the bureau of home economics, published by the Department of Agriculture.

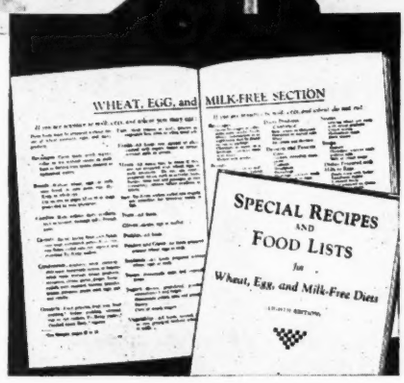
It contains new average values covering more than 1100 plant and animal foods found in American markets. The values are reported in terms of percentage for refuse, water, protein, fat, ash, total carbohydrates and fiber. Sugars, starch and acid are reported for some foods. Fuel value is given in terms of calories per hundred grams and per pound. No data on the mineral or vitamin content of foods are included.

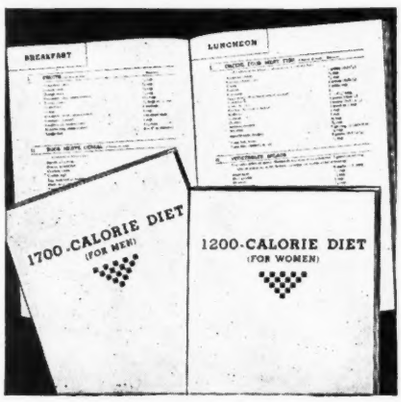
These figures on food composition supersede Office of Experiment Stations Bulletin No. 28, "Chemical Composition of American Food Materials," by W. O. Atwater and A. P. Bryant, last revised in 1906. For the benefit of persons who are preparing diets for diabetic patients, a classification of fruits and vegetables according to their carbohydrate content is included. It is available at 15 cents a copy from the superintendent of documents, Government Printing Office, Washington, D. C.

Serve RY-KRISP

. . . the all-purpose whole rye wafer

Ry-Krisp is a crisp, whole-grain wafer. Appetizing, nourishing, economical to serve. *Ry-Krisp is available in hospital-size cartons containing 576 wafers. Ask for special prices.*





RY-KRISP IMPORTANT IN SPECIAL DIETS

1. As a safe bread in allergy diets — Made simply of whole rye, water and salt, Ry-Krisp is recognized by leading allergists and dietitians as a safe bread for patients sensitive to wheat, milk or eggs. Write for free Ry-Krisp Allergy Diet Booklets, giving allowed and forbidden foods and including a variety of recipes for delicious dishes which can be prepared without wheat, milk, or eggs. No advertising shown.

2. As an ideal bread in low-calorie diets — Because Ry-Krisp contains only 20 calories per wafer yet supplies minerals and helpful bulk, doctors agree it has a valuable place in low-calorie diets. 1200-calorie diets for women and 1700-calorie diets for men are now offered free to hospitals. These Diets list a wide variety of everyday foods which are simple to prepare, economical to serve. Write for free supply.

FREE TO HOSPITALS: Low Calorie Diet Booklets, Allergy Diet Booklets including valuable recipes, also generous samples of Ry-Krisp sent free on request to hospitals. Simply write request on your letterhead and address to Ralston Purina Company, St. Louis, Missouri.

Fresh Grapefruit on the Menu

MARIE V. KRAUSE

UNTIL recently the favorite American breakfast has been considered to include orange juice, toast and coffee. However, with the growing interest in new foods as a result of widespread nutritional education, this average breakfast is undergoing a change. Other fruits and fruit juices, such as the fresh grapefruit, are becoming equally popular with orange juice in homes and institutions.

To bear out this impression, a study was carried out at New York Hospital, New York City. Fresh grapefruit, in halves or in juice, was served three times a week for approximately four months to all patients on the pavilions who were allowed fresh fruit in their diets. Table 1 demonstrates the approval with which fresh grapefruit was received.

A large percentage of the patients ate the fresh grapefruit, while only a very small percentage (0.3 per cent) refused. The chief reasons for refusing the fresh grapefruit were: (1) the patients were too ill to eat, and (2) they did not feel like eating or thought the effort of eating the grapefruit halves was too great. The number that did not take the fruit because of a definite dislike was small.

In addition, a study was conducted on patients who were permitted to check a selective menu. Out of 1863 patients offered a selection of fruit, 1325, or 71 per cent, preferred grapefruit to any other fruit on the menu. Some of the patients who did not select grapefruit did not desire fruit and a few were too ill to eat.

Such fruits as grapefruit, orange, pineapple, lemon, lime and tomato are the chief dietary sources of vitamin C, and the adequate, or protective, diet usually includes one serving of citrus fruit daily to assure protection against a deficiency of this vitamin.

The author is in the department of nutrition of the New York Hospital, New York.

Table 1—Analysis of Patients' Attitude Toward Fresh Grapefruit

Type of Patients	*Number of Patients*	*Type of Preparation*	*Number Who Refused*	*Number Who Requested Sugar*
Medical	749	Halves	42	147
	207	Juice	0	0
Surgical	1407	Halves	81	31
	1293	Juice	0	0
Urologic	485	Halves	40	39
	9	Sections	0	0
	271	Juice	0	0
Lying-In	3245	Halves and Juice	63	9
Total	7666		226	226

Table 2 is a summary of the comparative vitamin C values of these fruits:

Table 2—Vitamin C Content of Fruits per Hundred Grams Edible Portion[1]

Fruit	*Mgm. Cevitamic Acid*	*International Units*
Fresh lemon juice	60	1200
Fresh orange juice	50	1000
Fresh grapefruit juice	40	800
Fresh lime juice	30	600
Fresh tomato juice	30	600
Canned tomato juice	25	500
Fresh pineapple	25	500

[1]Taken from "The Vitamins." Chicago: American Medical Association Press, 1939.

Assuming that 1000 international units (50 mgm.) of vitamin C per day are adequate for an adult, the entire daily requirement can be met by choosing one of the varieties shown in table 3.

Table 3—Sources and Amounts of Vitamin C

Fruit	*Grams*	*Household Measure*
Fresh lemon juice	85	3 oz.
Fresh orange juice	100	3⅓ oz.
Fresh grapefruit juice	125	4 oz.
Fresh lime juice	165	5½ oz.
Fresh tomato juice	165	5½ oz.
Canned tomato juice	200	6⅔ oz.
Fresh pineapple juice	200	6⅔ oz.

Contrary to previous reports, Prof. Arthur W. Thomas of the department of chemistry, Columbia University, has found that uncontaminated fresh fruit juices may be kept in the refrigerator at a temperature of from 35° F. to 40° F. for twenty-four hours without an appreciable diminution of vitamin C. This is an important finding to hospitals where it is often necessary to extract breakfast juice the night before in order to save time.

Contamination by copper is a destructive factor because minute quantities of it are capable of catalyzing the oxidation of cevitamic acid, thereby destroying the vitamin quality. Therefore, equipment used in extracting and storing the juice must not contain copper. Glass, china, stainless steel and tin are safe materials to use.

In appraising the adequacy of patients' daily food intake at home, one is impressed with the fact that if even a moderate amount of citrus fruit is included the diet is adequate in vitamin C. The cost of fresh grapefruit is comparatively low considering its health advantages and it should occupy an important place in the patient's diet.

Dietary Uses of Bananas

DIETARY USES OF THE BANANA IN HEALTH AND DISEASE. *By L. Jean Bogert, Ph.D. Berkeley, Calif.: United Fruit Company. July* 1940. *Pp.* 63.

Dietitians and physicians will be interested in this pamphlet which covers all of the important papers written during the last five years on the subject of the composition and the clinical evidence surrounding the dietary uses of the banana.—D. DEH.

Its Refreshing Stimulation Cheers Patients and Helps Keep Up Their Spirits

And that's particularly true of Continental Coffee because it is a blend of extra-strength... extra-richness . . . and full satisfying flavor. It relieves nervous strain, gives a lift to fatigued minds and tired bodies. Yet with all its exceptional deliciousness and full-flavored satisfaction, Continental Coffee is more economical to serve . . . *it actually costs less per cup!*

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October Menus for the Small Hospital

Jane E. Smith
Dietitian, Chicago Memorial Hospital, Chicago

	Breakfast		Luncheon or Supper				
Day	Fruit	Main Dish	Soup or Appetizer	Main Dish	Potatoes or Substitute	Vegetable or Salad	Dessert
1.	Fresh Applesauce	Scrambled Eggs	Tomato Juice	Broiled Sardines on Toast		Vegetable Salad	Peaches
2.	Stewed Apricots	Poached Egg on Toast	Cream of Pea Soup	Grilled Apples, Pork Sausage	Sweet Potato Rosettes	Cabbage and Carrot Salad	Devil's Food Cake
3.	Tomato Juice	Bacon	Cream of Beet Soup	Creamed Hard Cooked Eggs on Toast		Tomato Salad	Watermelon
4.	Stewed Prunes	Soft Boiled Eggs	Oyster Stew	Melon, Grape, Cream Cheese Salad	Baked Stuffed Potato	Buttered Carrots	Lemon Gingerbread
5.	Sliced Bananas	Pancakes With Syrup	Cream of Asparagus Soup	Spaghetti With Meat Balls		Fresh Peas, Banana Wedge Salad	Fresh Sliced Pears
6.	Grapefruit	Pork Sausage, Coffee Cake	Cream of Mushroom Soup	Tunafish Salad With Tomato Wedges and Potato Chips		Parker House Rolls	Apricots
7.	Fruit Compote	Baked Eggs	Cream of Pea Soup	Cold Meats, Spiced Plums	Duchess Potatoes	Molded Fruit Salad	Butter Cookies
8.	Stewed Figs	Bacon	Oxtail Soup	Baked Macaroni and Cheese		Fresh Vegetable Salad	Mixed Fresh Fruit Cup
9.	Plums	Omelet	Cream of Green Bean Soup	Salmon Salad With Noodles	Potato Chips	Buttered Beets	Pecan Rolls
10.	Stewed Apricots	Grilled Ham, Muffins	Cream of Tomato Soup	Poached Egg in Spinach Nest		Fresh Pear Salad	Rice and Raisin Pudding
11.	Baked Apples	Soft Boiled Eggs	Cream of Celery Soup	Welsh Rabbit With Bacon	Grilled Tomatoes	Fresh Asparagus	Baked Peaches
12.	Orange Juice	Poached Eggs	Cream of Pea Soup	Chicken Giblets With Rice in Creole Sauce		Fresh Pear and Date Salad	Pound Cake With Butter Icing
13.	Grapefruit	Bacon, Coffee Cake	New England Clam Chowder	Cold Meat	Baked Potato	French String Beans	Fruit Cup Ambrosia
14.	Pineapple Juice	Scrambled Eggs	Cream of Celery Soup	Bacon and Tomato Sandwich	Candied Sweet Potatoes		Spice Cake With Orange Icing
15.	Stewed Prunes	Bacon	Tomato Bouillon	Egg Cutlets With Cheese Sauce		Vegetable and Fruit Slaw	Apricot Whip With Custard Sauce
16.	Cinnamon Quartered Apples	Coddled Eggs	Broth With Noodles	Hot Roast Beef Sandwich		Orange and Grapefruit Section Salad	Chocolate Pudding
17.	Blue Grapes	French Toast With Syrup	Cream of Beet Soup	Creamed Chicken and Mushroom Tips on Toast		Peach and Nut Salad	Fruit Gelatin With Cream
18.	Stewed Apricots	Scrambled Eggs	Oyster Stew	Fruit Plate: Orange, Grapes, Banana, Apple, Sliced Cheese		Potato Chips	Tapioca Pudding
19.	Orange Juice	Bacon	Cream of Tomato Soup	Creamed Sweetbreads on Toast		Cabbage, Pineapple, Raisin Salad	Orange Rolls
20.	Grapefruit	Pork Sausage, Coffee Cake	Fresh Shrimp Cocktail	Fresh Asparagus on Toast, Hollandaise Sauce		Cottage Cheese Salad	Grape and Pear Fruit Cup
21.	Sliced Bananas	Poached Egg on Toast	Chicken Soup	Hungarian Goulash		Carrot and Raisin Salad	Butterscotch Pudding With Nuts
22.	Baked Apples	Grilled Ham	Mulligatawny Soup	Potato Salad With Bologna		Fresh Peas	Plum Cake
23.	Stewed Apricots	Soft Boiled Eggs	Cream of Celery Soup	Creamed Chicken	Baked Potato	Cluster Grape Salad	Oatmeal Drop Cookies
24.	Pineapple Juice	Baked Eggs	Oxtail Soup	Toasted Cheese Sandwich With Bacon		Fresh Asparagus	Cherry Pandowdy
25.	Grapefruit Sections	Pancakes With Syrup	Potato Chowder	Vegetable Plate: Glazed Carrots, Fresh String Beans, Grilled Tomato		Peach and Cream Cheese Salad, Banana Muffins	
26.	Prune Juice	Poached Eggs	Beef Broth With Barley	Mashed Sweet Potato With Marshmallow, Grilled Apple, Sausage		Mexican Salad	Pineapple
27.	Orange Juice	Bacon	Cream of Mushroom Soup	Escalloped Tunafish With Cheese Swirls		Waldorf Salad	Frosted Graham Crackers
28.	Tomato Juice	Broiled Liver	Fruit Juice Cocktail	Fried Cornmeal Mush With Syrup		Perfection Salad	Baked Pears
29.	Stewed Peaches	Coddled Eggs	Cream of Tomato Soup	Cold Sliced Turkey Sandwich With Pickles		Baked Orange Salad	Tapioca Cream Pudding
30.	Grapes	Bacon	Oxtail Soup	Scrambled Eggs With Frizzled Dried Beef on Toast		Broccoli	Youngberries
31.	Grapefruit	Scrambled Eggs	Cream of Navy Bean Soup	Assorted Cold Meats, Escalloped Potatoes, Hot Rolls, Fresh Asparagus		Apple and Raisin Salad	Pumpkin Tarts With Cream

Recipes will be supplied on request by Anna E. Boller, The Modern Hospital, Chicago. Space precludes listing of cereals, several varieties of which are always offered for breakfast.

Dull appetites brighten when the tray brings piping-hot, delicious Toastmaster Toast!

DINNER TRAY

Cream of corn soup; bacon and tomato sandwich on Toastmaster Toast; creamed cauliflower; green peas; head lettuce with Russian dressing; cantaloupe with fruit; hot coffee.

TOAST is an attractive, easily digestible form of carbohydrate, ideal for Bland Diets, Surgery Diets, Smooth Diets, Low Residue Diets and as a supplementary food in Infant Feeding.

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Rights and Wrongs in Rug Care

GRACE H. WOOLLEY

"IF ONLY our rugs could be slip-covered" is the cry of many a housekeeper, both institutional and domestic, but to the hospital housekeeper such a device would probably prove the greatest boon of all. Because of the law of gravity, every movable object, be it solid or liquid, has an urge to settle to the floor and in a hospital there seems to be an unusual variety of objects to settle. This makes the maintenance of rugs a major source of worry.

Probably if hospital housekeepers could have their way, there would be no rugs used in the patients' rooms, certainly no large rugs. These require frequent and, when accidents occur, instant cleaning. Many times the patients are in no condition to have rugs removed for cleaning or to have a vacuum used in the room to remove dust and dirt.

The only thing to do with a rug when accidents occur is to wash it well and follow this with a thorough rinsing. This need not be difficult or in any way harmful to the rug if the correct procedure and proper cleaning compounds are used.

Frequently, a rug will look bright and clean after it has been washed but in just a few days the colors become dingy and the rug appears to be completely lifeless. This is probably because the soap and alkali used in washing have not been thoroughly rinsed out of the pile and warp. Both color and texture are affected by this, owing partly to the alternate dryness and dampness of the atmosphere and partly to the fact that every bit of dust and dirt in the air adheres to the oily residue in the carpet and resists all efforts of a vacuum cleaner to remove them. With constant washing and insufficient rinsing, the pile fibers become brittle and break. The warp rots and will eventually break.

To hospital rugs particularly, shampooing is a necessary method of cleaning and the technic and cleaning compound used determine whether or not the rug will have a bright or dingy appearance; whether the pattern will be clear or indefinite; whether the nap will be clean or sticky, soft or harsh, and whether the rug, when dry, will be sweet smelling or have an unpleasant odor. Technic plays an important part in this process but the soap used is of major importance.

Let us first consider the fundamental qualities of soap. What is it? It is a combination of soda or potash alkali with oils and fats. If too much soda or potash is added to the oil, it will remain in the soap in a free state; if too little soda or potash is used, some of the oil remains unsaponified. Either is bad. When just the right proportion of each is used we have what is called a neutral soap. If extra alkali is blended with the soap, the product is called "built" soap. But wool, which, to a great extent, forms the exposed surface of

Miss Woolley is manager of the national membership division, American Hotel Association, New York City.

Solutions and Procedures for Removing Stains

STAIN	REMOVER	METHOD
Ink, grease, alcohol, coffee, tea, iron oxide, apple, banana, cherry, berries	4 parts denatured alcohol; 1 part 99% glacial acetic acid, 1 part glycerin, 1 part oxalic acid	After applying to the rug, rinse thoroughly and follow with a 10% solution of ammonia. This is safe for all fabrics except cellulose acetate and for all dyestuffs except those that are applied to cotton.
Black ink, black dye, gum, shoe blacking, stamp pad ink	1 part nitrobenzene (oil of mirbane), 7 parts phenol (carbolic acid, U.S.P. 90% solution)	Work the stain with this mixture and follow with alcohol. The mixture can be applied safely to all dyestuffs common to floor coverings except cellulose acetate fiber, which it dissolves.
Laundry marking ink, argyrol, throat gargles (all stains containing nitrate of silver)	2 oz. potassium iodide, 1 oz. water, 1 oz. iodine crystals	Dissolve potassium iodide in water; add crystals and stir until dissolved. Add enough water to make 1 quart. Apply solution with dropper or brush. Remove iodine stain with any of the following: hyposulphite of soda; sodium hydrosulphite stripper; glacial acetic acid; ammonia (28%); 20% salt solution, or hot dry steam. If left on too long, iodine stain may cause total decomposition of the wool.
Blood, animal secretions, urine, cod liver oil emulsion, glue, milk, perspiration, protein, Russian mayonnaise, French dressing	Dilute 1 gal. water with 1 lb. common salt; mix with 2 oz. formic acid	Spot or soak the fabric in the solution for one hour or more, then rinse out with water. This may be safely applied to all fabrics. To correct brittleness in fur or woolen rugs and to recondition them after the extraction of the stain, apply equal parts neatsfoot and monopole oils.
Shellac, paint, varnish and oil solvents	Equal parts denatured alcohol and carbon tetrachloride	
Colored candle wax, cocoanut oil, finger nail polish, hair dye, lipstick, rouge, Thousand Island dressing, whisky	Equal parts denatured alcohol, acetone and 99% solution glacial acetic acid	In using the solution, care should be taken not to let it come in contact with the flesh because it will cause severe burns.

The Newer Concepts of Meat in Nutrition

The Protein of
Meat and its Advantages

THE need for protein, a constituent of all living tissue, is both qualitative and quantitative. In the light of current knowledge of biologic processes, ten amino acids (of the total of thirty now identified) are regarded as nutritionally indispensable. The list comprises tryptophan, lysine, histidine, phenylalanine, leucine, isoleucine, threonine, methionine, valine, and arginine. These ten amino acids are required for both growth and maintenance. Since they cannot be synthesized by the organism (except arginine which is produced in an insufficient quantity), they must be derived from protein-containing foodstuffs. An inadequate intake of one or more usually leads to retarded growth in the young and to an impaired state of health in the adult, as demonstrated in experimental animals.

Not only is protein necessary for growth, but it also enters into the chemical makeup of many hormones and enzymes; in addition it acts as a source of calories. Recent studies indicate that the optimum requirement for protein is from 80 to 100 grams daily, an amount which may not be supplied by the average diet. The protein requirements are higher during infancy and adolescence, and are increased by pregnancy, lactation, infectious fevers, hyperthyroidism, and protein loss as in nephrosis. Ingestion of amounts greater than the daily requirement is followed by deaminization of the excess, which may then be converted into glycogen. Careful observation has shown that a high protein diet exerts no deleterious influence on the normal organism, and that the normal liver and kidneys are not unduly overburdened by a large protein intake.

Meat offers many advantages as the daily source of protein: it is almost completely digested by young and old alike, yielding its amino acids without appreciable loss; the protein of meat, in contradistinction to the proteins obtained from many other sources, is nutritionally adequate, supplying all known essential amino acids in quantities sufficient for growth and for tissue maintenance and replacement without adding undue bulk to the dietary. Many nutritionists assert that meat should be the primary source of protein for the human organism.

Breuer, M. J.: Menus, Diets and Nutrition, Nebraska State M. J. *25*:222 (June) 1940.

Brockington, Fraser: The Dependence of Body-Weight on Animal Protein Foods: A Study of 120 Children in 63 Families, Public Health *7*:209 (April) 1939.

Hamilton, T. S.: Heat Increments of Diets Balanced and Unbalanced with Respect to Protein, J. Nutrition *17*:583 (June) 1939.

Jones, H. M.: Self-Selected Diets in Toxic Goiter, J.A.M.A. *115*:274 (July 27) 1940.

Kunerth, B. L., and Pittman, M. S.: Long-Time Study of Nitrogen, Calcium and Phosphorus Metabolism on Low-Protein Diet, J. Nutrition *17*:161 (Feb.) 1939.

Pittman, M. S., and Kunerth, B. L.: Long-Time Study of Nitrogen, Calcium and Phosphorus Metabolism on Medium-Protein Diet, J. Nutrition *17*:175 (Feb.) 1939.

Stengle, A., Jr., and Ravdin, I. S.: The Maintenance of Nutrition in Surgical Patients, with a Description of the Orojejunal Method of Feeding, Surgery *6*:511 (Oct). 1939.

The Seal of Acceptance denotes that the statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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American Meat Institute
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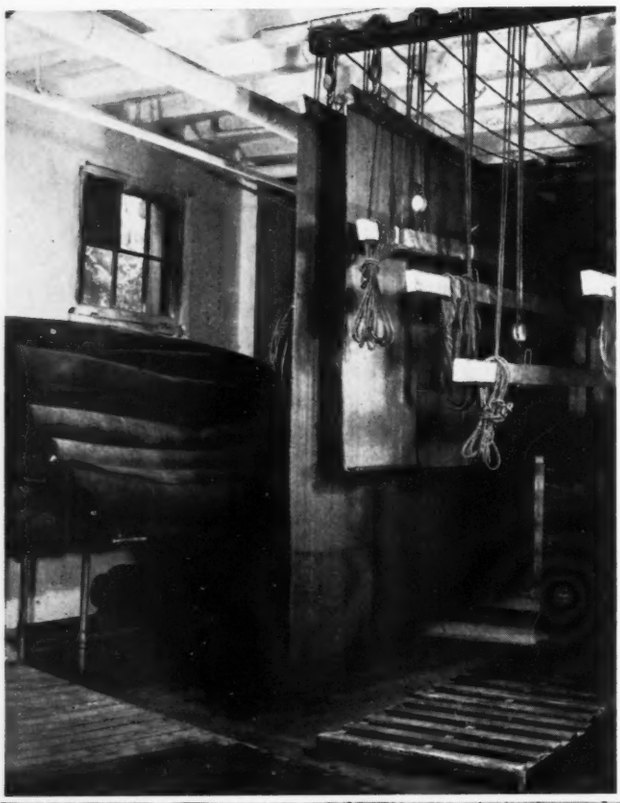
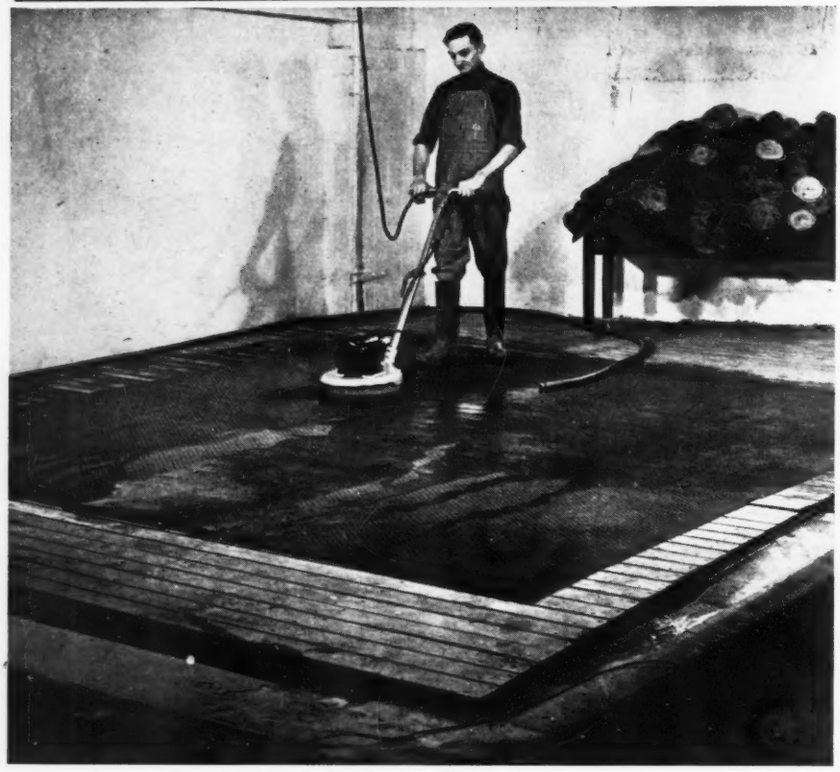


Below: A maintenance man at Michael Reese Hospital, Chicago, washes a rug on a slatted frame, elevated to allow the water to drain. No. 1 cypress wood was employed to make the frame because it will withstand the constant flow of water without rotting. Left: After they have been washed, the rugs are suspended on racks that can be raised by means of a pulley.



rugs, is sensitive to alkalis. They tend to make wool lose its resilience and become harsh. They also affect the dyes with which the wool is colored. Unless the soap is chemically tested, it is difficult to know whether the blend is exactly right.

A few years ago an entirely new product appeared on the market, one that has all the advantages of soap but none of the disadvantages. It was tried out skeptically at first but today it is used by practically every type of textile wet-finishing process. This product is made of sulphated fatty alcohols and is commonly known as "soapless soap." It is ideal for rug cleaning. It may be used with equal efficiency in water of zero, 2 grain or 50 grain hardness. Regardless of the condition of the water, no lime particles, even if they are formed in water of 1 or 2 grains hardness, will adhere to the fibers of the rug. This adherence of lime is what causes odor difficulties and takes out color.

Another important factor is the feel of the rug. Rugs with lime soaps on them feel harsh and sticky. A rug that is cleaned with sulphated fatty alcohol has an entirely different feel. There is no harshness or stickiness. It has the same soft "plump" feel that the carpet had when it was new. Also, sulphated fatty alcohols preserve colors and prevent bleeding of dyes. Their use cuts down the cleaning time because they leave the fibers of the rug free and open and they do not require a heavy brushing to bring them back to their original luster. These soapless soaps are now sold by all of the leading soap manufacturers under various trade names and most of the carpet cleaning equipment manufacturers sell or recommend these products.

If a thorough wetting of the rug is necessary, which necessitates the use of gallons of water, about the only thing to do is to send the rug to the cleaners, as most hospitals do not have the equipment or space for such thorough cleaning. However, Mrs. Alta La Belle, housekeeper at Michael Reese Hospital in Chicago, found it possible to get around this difficulty.

She had a latticed frame built, of sufficient size to handle the largest rugs in her patients' rooms, 15 by 18 feet. This was placed at an incline of about 4 inches just above a cement floor with a good drain in it. The soiled rugs are fastened on the frame and thoroughly scrubbed and rinsed until the water runs clear. She also had a frame built at one side of the room, which works by pulleys from the ceiling. The clean rugs are fastened on this frame, which can be built to hold any number of rugs, and drawn up to the ceiling where they hang until they are dry. Mrs. La Belle is highly pleased with this method because she knows that the rugs are thoroughly clean and they are out of service no longer than two days. The entire arrangement cost less than $200 and takes up little space.

Inasmuch as such a thorough cleaning is not always necessary, a thoroughly satisfactory job can be accom-

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Experimentation is hazardous in any attempt to solve an important hospital need.

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Typical Examples of Recent Hospital Appeals

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MONTREAL, QUE.
$304,000 raised
for expansion and debt

Hospitals Council
SANDUSKY, OHIO
$106,000 raised
for debt liquidation

Peninsula General Hospital
SALISBURY, MD.
$159,000 raised
for new building

Michael Meagher Hospital
TEXARKANA, ARK.-TEX.
$135,000 raised
for new building

Charlotte Memorial Hospital
CHARLOTTE, N. C.
$215,000 raised
to complete building program

N. C. Baptist Hospital
WINSTON-SALEM, N. C.
$220,000 raised
for new building

WRITE FOR THE BOOKLET — *"Thirty Years in Hospital Finance"*

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FIFTY-FIRST FLOOR · RCA BUILDING · ROCKEFELLER CENTER · NEW YORK, N. Y.

plished with the modern portable cleaning units and scientific cleaning compounds. There is no doubt as to the convenience and economy of this method. These machines are power driven and have a rotary action. The cleaning compound is fed through a tank on the machine to a revolving brush, which whips it into a heavy suds as it is guided across the carpet by the operator. A second machine works like a vacuum and extracts the water and suds.

Within the last six months there has appeared on the market an excellent carpet shampoo machine that seems to be made to order for hospital use since it is particularly adapted to small rugs—9 by 12 feet, 15 by 18 feet and small scatter rugs. This is hand driven rather than power driven, weighs about 10 pounds and is easy to operate. It works in a straight line rather than with rotary action which, particularly in the case of twisted pile carpets, seems more scientifically correct.

The first step in the cleaning of floor coverings is to extract as much of the loose dust and grit from the fabric as is possible. If this is not done before the liquid solution is applied, there is just that much more soil to dissolve, and by creating so much muddy solution, the moisture content and, consequently, the drying period of the fabric are increased.

When the dust has been thoroughly extracted, the operator shampoos the rug by starting at one end and running the brush slowly across the length or width. If a soapless soap compound is not used, the suds should be extracted from the fabric before it breaks down and is converted into liquid and penetrates the warp. In this case, and if only one man is doing the cleaning, it is advisable to stop the first operation after two or three passes across the rug and extract the suds. If each section cleaned is overlapped slightly, no streaks will be left in the carpets.

Following this procedure and regardless of the compound used, if the operator will saturate a large turkish towel in warm water, wring it out tightly and wipe the entire pile of the carpet lightly, rinsing the towel out frequently, the appearance of the carpet will be greatly improved. Adding about one pint of denatured alcohol to a pail of clean warm water further improves the cleaning job. When this has been done, the operator should brush the rug carefully with a fine, stiff dry brush so that the pile stands up. The carpet or rug should not be walked upon until it has thoroughly dried to prevent the pile's being pressed down. When dry, the pile can be brushed in the proper direction and it will appear perfectly uniform.

The best part of the entire process is that, with the new soapless soaps, the suds or lather left in the rugs does no harm and forms no sticky or oily base to attract dirt. Also, the compounds can be made up in an acid solution and create a suds equally as well as in water, and an acid detergent has a tendency to revive colors that have become slightly faded.

To make an acid solution, dissolve 2½ pounds of soapless soap powder in a small amount of water to form a thin paste; dilute it with sufficient water to make 12 gallons, and add from ½ to 1 pint of glacial acetic acid. Never apply an acid solution to a carpet or rug while any soap residue is present in the fabric.

Before a rug is shampooed or cleaned, it is always advisable to remove stains. Grease spots are usually removed by the use of carbon tetrachloride or by various commercial cleaners. To remove the spot, saturate it with the solution and squeeze the dirt or grease away with a porous cloth. Often a grease spot can be removed merely by placing a blotter over the spot and applying dry heat.

Holes in the rug or carpet that are caused by burns, moths or worms can be patched by burling or tying new tufts to take the place of those that are missing. Sometimes little ends of pile or warp will appear above the surface of a new carpet or rug. Never pull them out but clip them off with shears.

Taking Linen Inventory

JACK G. CHARLÉ

IN ORDER to take inventory of the hospital's linens correctly, the housekeeper must be familiar with every location of the hospital in which linen may be stored or hidden.

The hospital linen stock is constantly circulating. This means, first of all, that inventory can be taken only at a given time when the housekeeper is reasonably sure that all soiled linens have been removed from the floor. To accomplish this, floor linens should be counted after patients' beds have been made and all soiled linen has been collected.

With the cooperation of the nursing department it should be possible to have one nurse assigned to take inventory on each floor. It is not advisable to split up the floor inventories among several nurses. Such inventories should be taken from room to room and checked off on previously prepared lists.

All closets and dresser drawers should be opened and checked because these are favorite hiding places for extra linens. The patient's bed should be examined for extra pillow cases or towels put under the mattress or for large sheets that may have been used in place of draw sheets. If the hospital does not possess a linen chute, the porter counts the soiled linen that has accumulated in the floor's linen hampers after laundry collections have been made. All floor inventories should be sent to the housekeeper's office.

To arrive at a correct inventory, a number of places have to be checked for linen contents, which are then added to the nurse's inventory. Her first concern must be the laundry. Having accounted for the laundry production on the day of inventory, she should check: (1) reserve stock in laundry or linen room; (2) linens that must be washed over; (3) linens that have been put aside for mending, and (4) soiled linen that the wash room has not laundered.

Special reserve stock for use on operating room or similar floors is often carried by the hospital for purposes of emergency and must be included. Many hospitals replace their discarded linens on the first of each month and, if the inventory is not taken immediately after the first, a list of such discarded linens should be included.

Mr. Charlé is in charge of maintenance at Beth-el Hospital, Brooklyn, N. Y.

Announcing

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Legal Light on Pharmacy

EMANUEL HAYT

THE practice of pharmacy demands knowledge, skill and integrity on the part of those who are engaged in it. This knowledge cannot be confined to professional subjects, such as pharmacognosy, pharmaceutical analysis, prescription and dispensing, but must include an acquaintance with pharmacy laws.

To ensure proper skill on the part of those who fill prescriptions, the various states have made it illegal for any person other than a registered pharmacist or registered assistant pharmacist to compound and sell drugs, poisons or medicines except for certain domestic or household remedies.[1] Such power to regulate the prescription, compounding of prescriptions and purchase and sale of drugs and medicines is inherent in the state police power.[2]

Must Exercise "Ordinary Care"

A registered pharmacist is required by law to possess a reasonable and ordinary degree of knowledge and skill in his profession.[3] In applying this knowledge and in exercising care and diligence, the pharmacist must give to the patient the benefit of his best judgment. The "ordinary care" that he owes to patients of the hospital must be considered in the light of the drugs with which he deals and the grave and even fatal consequences that may follow the want of due care.[4]

The pharmacist must know the properties of the drugs he handles and their effect upon those who will use them. When that knowledge causes him to recognize that a prescription, as he reads it, calls for so great an amount of an ingredient as to be almost certain to cause injury, if he does not use that knowledge and ascertain the true ingredient or proportion to be used, he is liable for the harm caused. He not only must possess the skill and knowledge but he must use them.[5]

Liability for Lack of Skill

It is the duty of every pharmacist to know the properties of the medicines that he compounds, to be capable of discriminating between them and to compound according to the prescription. If he departs from the prescription or introduces other poisonous drugs he is responsible for the consequences.[6] The pharmacist is further liable if he mixes the proper medicines in the wrong proportion or does not mix them thoroughly. He is under an obligation to know that such conduct will produce serious illness or death in the event that the user gets an overdose of a dangerous drug.[7] His liability for lack of skill has been established when he includes an unsuitable although not necessarily poisonous drug for the needs of the patient, as well as when he puts in a harmful drug in place of the proper harmless one.[8]

The amount of care required to be called "due care" is the degree exercised by the average member of the profession in similar circumstances in the locality.[9] The courts have sought to be definite about the requirement of due care but with little success; the test is still vague. In one instance the court declared that: "In such case ordinary care calls for a degree of vigilance and prudence commensurate with the dangers involved."[10]

Inasmuch as the average patient has no definite knowledge of medicines in the U. S. Pharmacopoeia or National Formulary, he must rely on the skill of the pharmacist. As the danger increases, the degree of care must increase.[11] "The case, it must be conceded, is one in which a very high degree of care may justly be required. People trust not merely their health but their lives to the knowledge, care and prudence of druggists and in many cases a slight want of care is liable to prove fatal to someone. It is, therefore, reasonable that the care should be apportioned to the danger involved."[12]

May Refuse to Fill Prescription

The pharmacist who refuses to fill a prescription for a physician does not render himself liable in damages to such physician. As a chemist, a pharmacist may suspect that the physician has erred in his prescription, or he may not have at hand the ingredients, or he may distrust his own ability to prepare the prescription, or he may have some other reason for declining to fill it. Recognizing all these causes, it cannot be held that the mere refusal furnishes any occasion for damages to the physician.[13]

A pharmacist, after filling a prescription and delivering the medicines, undoubtedly has the absolute right to retain the prescription but if he refuses to deliver the medicines called for by the prescription he cannot retain the prescription against a demand for its return. If the medicine is not delivered, he can have no need of the prescription as a business record or as an instrument of evidence. Having received a prescrip-

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The author is a partner of the law firm of Hayt and Hayt, New York.

[1]Pratter *v.* Lascoff, 261 N.Y. 509, 185 N.E. 719.

[2]Liggett Company *v.* Balrige, 278 U.S. 105, 73 L. Ed. 207.

[3]Tremblay *v.* Kimball, 107 Me. 53, 77 A. 405.

[4]Smith *v.* Middleton, 112 Ky. 588, 66 S.W. 388.

[5]Tombari *v.* Connors, 85 Conn. 231, 82 A. 640.

[6]Fleet *v.* Hollenkemp, 52 Ky. (13 B. Mon.) 219, 56 Am. Dec. 563.

[7]Coughlin *v.* Bradbury, 109 Me. 571, 85 A. 294.

[8]Edlestein *v.* Cook, 108 Ohio St. 346, 140 N.E. 767.

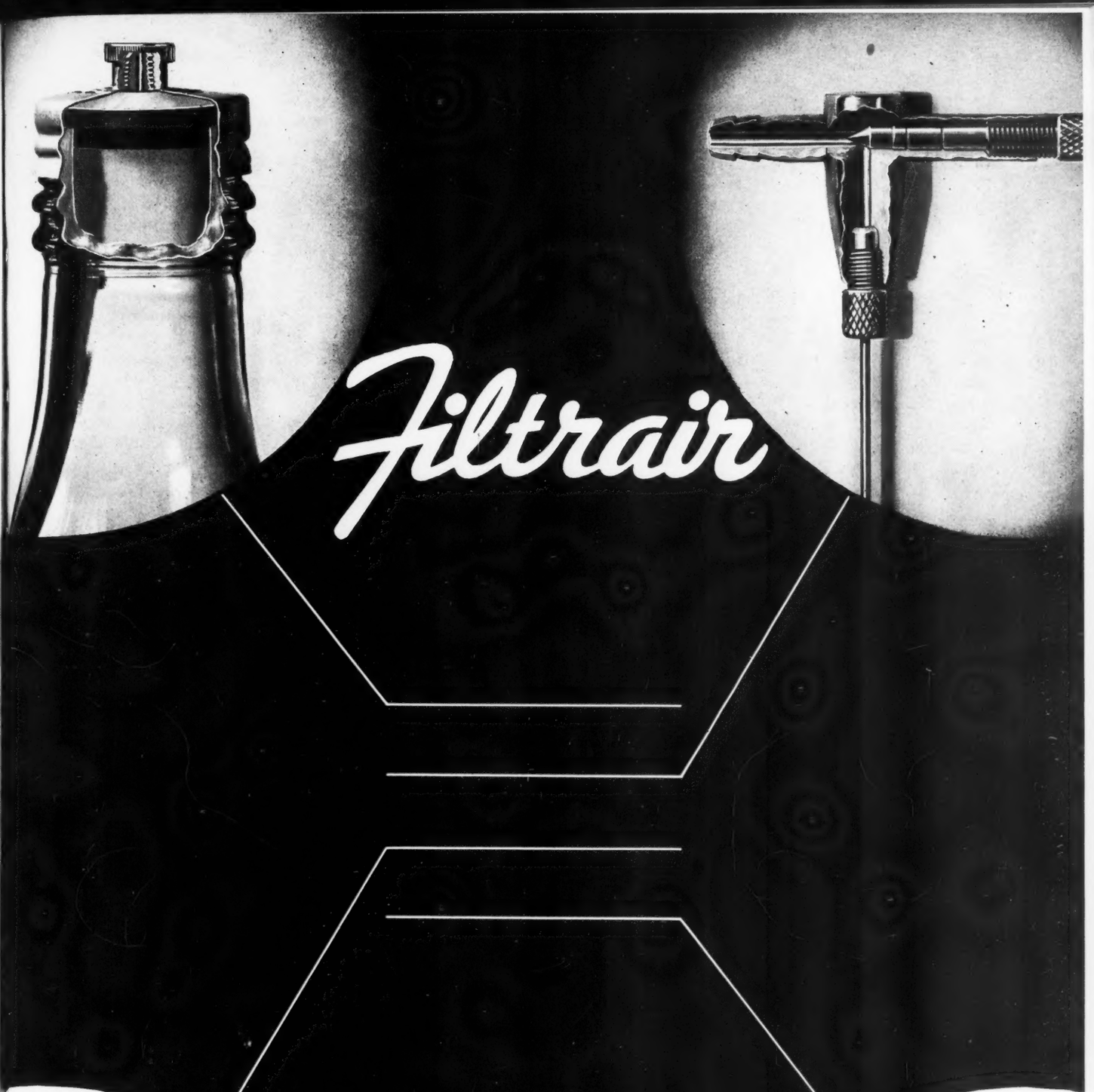
[9]Ohio County Drug Co. *v.* Howard, 201 Ky. 346, 256 S.W. 705.

[10]McGahey *v.* Albritton, 214 Ala. 279, 107 So. 751.

[11]Beckwith *v.* Oatman, 43 Hun. 265 (N.Y.)

[12]Brown *v.* Marshall, 47 Mich. 576, 11 N.W. 392.

[13]Tarleton *v.* Lagarde, 46 La. Ann. 1368, 16 So. 180.



The Filtrair Haemovac

The Filtrair Haemovac undoubtedly introduces more innovations into the field of transfusion to facilitate the drawing, citrating, storing, filtering and dispensing of blood than any apparatus existing at the present time. Every precaution has been taken to make this apparatus simple, understandable, and easy to operate. All the difficulties heretofore attended by vacuum indirect transfusion methods have been obviated. No longer is it necessary for you to have special tools, scissors and other devices in order to accomplish the operation, and moreover it is now possible with the screw cap on the Filtrair Haemovac to be sure that the orifice of insertion is sterile; that the needle of the Filtrair blood valve will be inserted in just the right place and that you can reclose the container and use the Filtrair Haemovac in blood banks and keep them the usual allotted storage time without the danger of contamination.

Filtrair Haemovacs are supplied in three types. One contains sufficient Sodium Citrate 2½% solution for the withdrawal of 250 cc. of blood. Another contains sufficient citrate solution for the withdrawal of 500 cc. of blood. The third type contains no citrate solution but does contain a high vacuum, and has been found useful in numerous drainage operations. The Filtrair Accessory Cap which is furnished for use with the Filtrair Haemovac is provided with a stainless steel tube, preventing any clotted blood from obstructing air vent.

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The Filtrair Blood Valve

The Filtrair Blood Valve is a fine piece of surgical equipment that can be assembled without the use of wrenches; it is well balanced and allows the operator to rotate the container without danger of disturbing the knurled knob thus causing the drawing of blood to be a failure. It can be cleaned very simply because removal of the Valve stem allows through and through cleaning. The apparatus is made of stainless steel and will last a lifetime under proper care. An extra needle assembly is included in each set. Our valve is packed in a convenient and handsome case.

The operation of the apparatus is most simple. In taking the donor's blood, the small screw cap of the Haemovac is removed, the needle of the Filtrair Blood Valve is inserted into the only hole provided in the top of the Haemovac, and which is always sterile. The needle attached to the tubing from the valve is inserted into the donor's vein. The Filtrair Blood Valve is gradually opened. The donor's blood flows into the Haemovac, the Haemovac is gently swirled with rotary motion which mixes the blood with the citrate solution and completely obviates the formation of clots.

tion, he should either deliver the medicine or return the prescription.[14]

In the event that the pharmacist causes injury through negligence in filling a prescription he must answer for any pain and suffering that are caused.[15] Not every error, however, is negligence; he does not guarantee that no error shall be committed in the discharge of his duties. There have been errors and mistakes that were not held to be actionable negligence. The question was raised in one case as to whether the delivery of a deleterious drug constituted a basis for damages at law, despite the lack of intentional wrongdoing or negligence on the part of the pharmacist. In holding that there must be evidence of actual negligence to give rise to a cause of action against the pharmacist, the court pointed out that an error might occur without fault on the part of the pharmacist. He may have obtained the drugs from a reputable dealer in whose warehouse they have been tampered with for the purpose of mischief. "It is easy to suggest accidents after they come to his own possession or wrongs by others of which he would be ignorant and against which a high degree of care would not give perfect protection."[16]

Inference of Negligence

Proof of a mistake in filling an order, while it is not of itself enough to impose liability, nevertheless, gives rise to an inference of negligence which the pharmacist must rebut by proper proof. Thus, in a case in which a pharmacist dispensed to a patient a bottle of witch hazel that, in fact, was silver nitrate solution his defense that he had obtained the witch hazel in bulk and packaged it without first analyzing it was sufficient to indicate negligence on his part.[17] When a harmless drug is prescribed and a poisonous one is provided, such act is *prima facie* negligence; unless rebutted by adequate proof the pharmacist is rendered liable.[18]

The use of strychnine by a pharmacist in filling a prescription that called for a camphor preparation establishes negligence *prima facie* and, in the absence of a satisfactory explanation as to how the mistake occurred, the pharmacist will be liable.[19] If a pharmacist negligently dispenses poison instead of paregoric, which is taken by the patient in the belief that it is paregoric, the pharmacist is responsible.[20] If he furnishes laudanum for tincture of rhubarb, thereby causing death, he is answerable in damages.[21] Similarly, he is liable if he provides cyanide of potassium for salts.[22]

Errors in Labeling

When a pharmacist mistakenly writes on a label a direction to take a teaspoonful of Fowler's solution of arsenic three times daily and the prescription called for only three drops of this in water after every meal, the pharmacist is held liable for death caused by an overdose.[23] In short, the rule is that liability attaches to the pharmacist for any injury caused by careless mislabeling of a drug.[24]

A pharmacist who carelessly labels a poison as a harmless medicine and dispenses it so labeled to the public is liable to any person who, without fault on his part, is injured by using it because he relied on the label, even though it may have passed through many intermediate hands before reaching him.[25] When a pharmacist bottles a drug that he has obtained in bulk and places his own label on it, he implies a warrant that it is what he represents it to be; upon proof of the slightest negligence, he is liable for any injury that may result from its use.[26]

When a statute requires that a poisonous drug be conspicuously labeled as such, failure to observe the statute is *per se* neglect of duty as well as neglect of care.[27] A statute that makes it a crime for a pharmacist to sell poison at retail without a physician's prescription, unless he first satisfies himself that it will be used for legitimate purposes, is a valid law.[28] However, a statute that requires a pharmacist to label all poisonous substances as "poison" does not apply to medicines compounded by pharmacists upon the prescription of physicians, although they contain poisons.[29]

It was held negligence *per se* to fail to comply with a statute making it a misdemeanor to deliver or sell any poisonous liquor or substance without having the receptacle labeled "Poison." Violation of such statutes is negligence.[30] Selling wood alcohol instead of the grain alcohol called for, without labeling the bottle to indicate its poisonous contents, was held negligent even though the article was intended to be used externally on animal or man.[31]

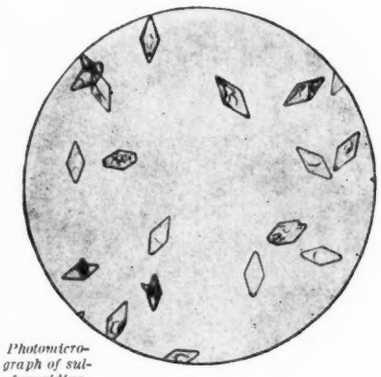
Equally Liable With Physician

A pharmacist will be liable if he fails properly to mix the ingredients of a prescription so as to distribute them evenly throughout the powders.[32] If a pharmacist is negligent in filling a prescription, he cannot escape liability because the doctor who wrote the prescription is also liable; a pharmacist may be liable if he merely fills a prescription as written by a physician if it calls for obviously fatal doses.[33] When doses appear to be unusual the pharmacist is bound to inquire of the physician to be sure there has been no error.[34] In filling a prescription a pharmacist will be held liable for substituting a drug other than the one called for.[35] The legibility of the writing in the prescription filled by the pharmacist is another factor to be considered in determining whether he was guilty of negligence.[36]

[14]White *v.* McComb City Drug Store, 86 Miss. 498, 38 So. 739.
[15]Corona Coal Co. *v.* Sexton, 21 Ala. App. 51, 105 So. 716.
[16]Brown *v.* Marshall, 47 Mich. 576, 11 N.W. 395.
[17]Highland Pharmacy *v.* White, 144 Va. 106, 131 S.E. 198.
[18]Edlestein *v.* Cook, 108 Ohio St. 346, 140 N.E. 765.
[19]Miner *v.* Scherpich, 5 N.Y. St. Rep. 851.
[20]Tucker *v.* Graves, 17 Ala. App. 602, 88 So. 40.
[21]Norton *v.* Sewall, 106 Mass. 143, 8 Am. Rep. 298.
[22]Meyer *v.* Flannery, 18 Ohio N.P.N.S. 361.
[23]Marx *v.* Schultz, 207 Mich. 655, 175 N.W. 182.
[24]Blood Balm Co. *v.* Cooper, 83 Ga. 457, 10 S.E. 118.
[25]National Savings Bank *v.* Ward, 100 U.S. 195, 25 L. Ed. 621.
[26]Highland Pharmacy *v.* White, 144 Va. 106, 131 S.E. 198.
[27]Sutton *v.* Wood, 120 Ky. 23, 85 S.W. 201.
[28]Commonwealth *v.* Katzman, 140 Ky. 124, 130 S.W. 990.
[29]Wise *v.* Morgan, 101 Tenn. 273, 48 S.W. 971.
[30]Burk *v.* Creamery Package Mfg. Co., 126 Iowa 730, 102 N.W. 793.
[31]Campbell *v.* Brown, 81 Kan. 480, 106 P. 37.
[32]Coughlin *v.* Bradbury, 109 Me. 471, 85 A. 294.
[33]People's Service Drug Stores *v.* Somerville, 161 Md. 662, 158 A. 12.
[34]Ibid.
[35]Wilcox *v.* Butt's Drug Stores, 38 N.M. 502, 35 P. (2) 978.
[36]Tombari *v.* Connors, 85 Conn. 231, 82 A. 640.

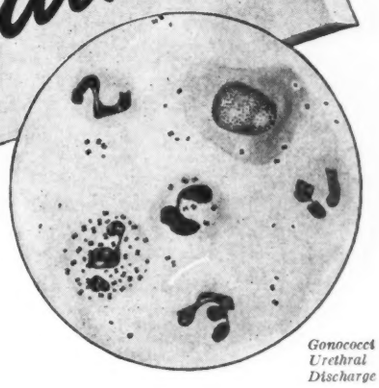
a noteworthy advance in the treatment of

GONOCOCCIC INFECTIONS



Photomicrograph of sulfapyridine crystals

Sulfapyridine



Gonococci in Urethral Discharge

The introduction of sulfanilamide in the treatment of gonorrhea admittedly represented a notable therapeutic advance. More recently, however, clinical studies have indicated that sulfapyridine may be even more effective than sulfanilamide in the treatment of this condition.

The great majority of patients with gonococcic urethritis treated with sulfapyridine experience a rapid subsidence of clinical signs and symptoms. Within a few days after the institution of sulfapyridine therapy, smears and cultures become negative for gonococci, the urine becomes clear, and urethral discharge ceases. Several cases which had failed to respond to sulfanilamide have later been treated successfully with sulfapyridine.

Thus it appears that in sulfapyridine the physician commands a potent therapeutic weapon for combating this widespread and distressing disease.

Council ACCEPTED AMERICAN MEDICAL ASSN. *Accepted*

Sulfapyridine is manufactured by Merck & Co. Inc. under license from the originators of the product, May & Baker, Ltd., of London. Supplies are available to the medical profession through their druggists under the labels of other leading manufacturers.

Literature on Request

MERCK & CO. Inc. *Manufacturing Chemists* **RAHWAY, N. J.**

NOTES AND ABSTRACTS

By Carl C. Pfeiffer, M.D., Department of Pharmacology
University of Chicago

Drugs and Wars

In the olden days before any specific remedies for illnesses were definitely known, a war or siege was more frequently won by dysentery and plague than by either army. With the growth of chemotherapy and the forward march of "blitzkrieg" therapeutic agents in step with "blitzkrieg" war, this state of affairs no longer obtains. But the blockading of ocean lanes by mines and destroyers may result in diminishing the supply of many vital therapeutic agents to the point of perilous exhaustion.

Arsphenamine

• At the outset of the World War the highly developed German dye industry alone was capable of manufacturing arsphenamine. Many syphilitic patients were already being treated with this potent new arsenical and, hence, the price rose enormously as the supply diminished owing to the effective British blockade. Inasmuch as syphilis must be treated continuously, the need was dire and, in 1915, the submarine *"Deutschland"* ran the blockade in order to bring a small supply of this valuable drug to America. Government subsidy and the urgent need for arsphenamine gave sufficient impetus to American ingenuity so that we are now independent and have many arsenical products that are equal to or better than any produced abroad.

"Germanin"

• Drugs have also entered into the peace negotiations of warring nations. At the recently much maligned Treaty of Versailles the Germans offered the French the use of and formula for Germanin, then known as "Bayer 205." They stated that this was more potent than any other agent against African sleeping sickness and, hence, important to the successful colonization of South Africa.

The French refused to accept the drug as part of the reparations agreement and, instead, set their expert organic chemist, Forneaux, to work to discover the formula, which he did and obtained a patent. While this chemically complex series of benzene rings linked together by polypeptide linkages is undoubtedly the most potent prophylactic and specific in African sleeping sickness, the relatively high cost of manufacture has prohibited its widespread use in many of the poorer districts of Africa, where the cheaper tryparsamide or atoxyl is still used instead.

Anesthetics

• During the World War the wounded were frequently anesthetized three or four at a time with the anesthetist walking to and fro to give a uniform ether or chloroform drop anesthetic. With the use of evipal (which the British have renamed "soluble hexobarbitone" because of the German origin of the previous name) and the even better pentothal sodium for intravenous anesthesia, the delay in treating casualties in the field hospitals in Britain has been markedly shortened. The British also have their own plant in which this thio derivative of pentobarbital can be manufactured.

Injected intravenously pentothal causes amnesia and anesthesia frequently before the patient can count slowly to 20. The anesthesia causes less nausea and vomiting than gas anesthesia and, a big advantage in the field hospital, the product is nonexplosive. It has the disadvantage of all fixed dose anesthetic agents in that there is no moment-to-moment control.

Ephedrine

• Synthetic chemistry has come to the aid of asthmatic and allergic patients with a wide range of substitutes for the active principle of the Chinese drug Ma Huang. The growth and export of this ephedrine-containing plant have been greatly curtailed since the Japanese invasion of China. The synthetics represent a wide range of pharmacological activity, while the synthetic ephedrine and epinephrin are equal in potency to the natural alkaloids, provided the same optical isomers are used. Neosynephrin, propadrine and benzedrine are all shining examples of the American chemist's ingenuity, for they are each pharmacologically potent drugs with improved action over the natural sympathomimetic amines, ephedrine and epinephrin.

Quinine

• Quinine, like rubber, is a strategic raw material produced in the Netherlands East Indies. With the mother country invaded, this insular possession is now also at the mercy of the warring nations. At present a blockade of the Netherlands East Indies would soon be accompanied by an increase in malaria, which is endemic in certain sections of our southern states. The only synthetic drug that is equal to quinine in the treatment of malaria is "atebrin." This is manufactured in this country from intermediates shipped from Germany. The availability of these intermediates depends upon the future ineffectiveness of the British blockade. If the blockade is effective, we may see some feverish haste in our chemical industry.

Ergot

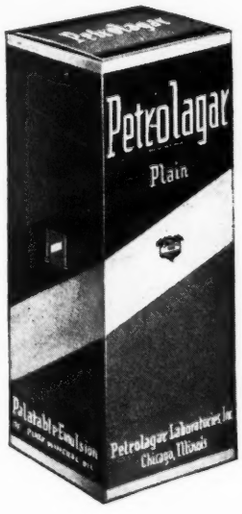
• When civil war broke out in Spain, this great rye-raising country's war affected the world drug markets. The fungus that produces the ergot alkaloids grows on rye; when collected by the peasants it is an added source of revenue but when left on the grain it is a frequent source of chronic poisoning. The alkaloid ergonovine derived from ergot is extremely potent in preventing postpartum hemorrhage after childbirth, while the alkaloid ergotamine tartrate, also derived from this fungus, is used effectively to relieve migraine headaches. Steps are now being taken to grow rye in this country and artificially to infect it with the fungus growth. Since this is largely hand labor, the cost is likely to remain relatively high for some time.

The Scientist and War

• In England at the present time a group of medical scientists is busy changing the names of all of the German-named drug products. For example, "avertin" is being changed to "bromethol." While this is in keeping with the general trend to change names to their chemical origin and do away with trade names, it also represents some of the strong national anti-German feeling in Britain. This compares mildly, however, with the religious nationalism evident in the German scientific press, in which tolerance and truth have been refrigerated and prejudice and "ersatz" doctrines placed upon the highest pedestal.

An example of this appeared in a recent survey of chemotherapy by W. Huebner of the University of Berlin. He states in the *Klinische Wochenschrift* when he refers to Domagk's discovery of sulfanilamide: "Once more a great discovery springs from the cortex of a German mind. When one looks through the enormous literature that has developed since, one finds among numerous American contributors to the subject also English and French. Were it not contrary to a sense of chivalry in one's attitude toward an enemy, one might be tempted to say with Schiller, 'When kings are building, hod-carriers find work to do.'"

Back to School---



★ ★ Petrolagar

Back to school again and a life of lessened activity that is likely to influence normal bowel habits. During this period of readjustment, consider the use of Petrolagar Plain.

Petrolagar is gentle, but thorough and may be prescribed for all ages as an aid to restoration of normal bowel habits. Most children cooperate willingly because Petrolagar is exceptionally palatable and easy to take just as it is, or in milk, water or fruit juices.

Petrolagar . . . Liquid petrolatum 65 cc. emulsified with 0.4 Gm. agar in a menstruum to make 100 cc.

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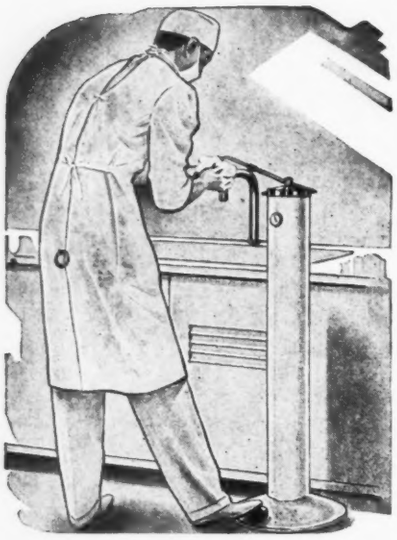

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"BUCKEYE" Surgical LIQUID SOAP

IT WILL PAY YOU to look into this—

First, satisfy yourself that "BUCKEYE" Surgical Liquid Soap lathers freely and cleanses thoroughly, *without producing the irritation* or roughness due to harsh soaps. It is a mild, neutral soap, produced scientifically from pure vegetable oils.

It "goes far" in dispenser use: one part "BUCKEYE" Liquid to three parts of distilled water means greater economy.

DISPENSER *GIVEN* FREE

You can actually OWN this practical, approved Dispenser without charge—not merely have the use of it on loan.

Your supply house can give you details. We will be pleased to send you a generous free trial sample of this soap if desired.

BUCKEYE Surgical LIQUID SOAP IS A PRODUCT OF THE DAVIES-YOUNG SOAP CO. DAYTON, OHIO

News in Review

New Conductive Rubber Expected to Increase Safety in Operating Rooms

A new type of conductive rubber that promises increased safety in hospital operating rooms was demonstrated in Chicago on August 13 before a large group of hospital executives, association leaders and members of the Hospital Industries Association.

While other rubbers in the past have been made conductive by impregnating them with various ingredients, this results in brittleness and a tendency to crack; the new rubber is said to have all the wearing, elastic and flexible characteristics of ordinary rubber.

The conductive characteristic of the new rubber can be regulated according to the wishes of the maker with an electrical resistance as low as one ohm or as high as 1,000,000,000,000,000 ohms per cubic centimeter. It can be made as hard as ebonite or as spongy as a medium-soft rubber. Within limits, any degree of conductivity can be associated with any degree of hardness, except that very soft rubbers cannot be made highly conductive.

The applications of the new rubber in hospital operating rooms will, its makers contend, supplant all other rubber now used in such places. If the new conductive rubber is used for the flooring, breathing bag and bellows on the gas machine, tips on the anesthetist's stool, soles for the shoes of the doctors and nurses in the operating room, cover for the pad on the operating table, casters and all other equipment where rubber could be used, it would mean that there would be a constant equalization of electrical potential throughout the room. It was suggested that, in addition, the floor should be grounded through a resistance coil to the steelwork of the building or to a water pipe. Thus, whatever charges may be built up through friction will seep off through the grounded flooring but will not be drawn off rapidly enough to cause a static spark.

It is recommended that the precautions previously enforced in operating rooms should not be relaxed even though the room is protected by conductive rubber at all points. Thus, the humidity should still be kept above 55 or 60 per cent; woolens, silk and most rayon fabrics should be prohibited; careful attention should be given to the maintenance of all electrical equipment; cauteries should be used cautiously and not around the head and shoulders of patients, and "no smoking" rules should be enforced.

At present the only operating room to be equipped with the conductive rubber equipment is one installed in the Underwriters Laboratories, Chicago, where extensive tests of the rubber are being conducted. Several hospitals, however, have ordered the rubber and equipment manufacturers are arranging to apply it to their products.

Five Employes Die in Cincinnati Hospital Fire

Five women employes of St. Francis Hospital, Cincinnati, were suffocated when fire destroyed an old building adjoining the hospital that housed the power plant and laundry and was also used as a residence for about 30 hospital workers. Several other employes were carried to safety by the firemen. The fire was discovered at about 1 o'clock on the morning of July 12. It had apparently broken out in a storeroom filled with boxes and trunks containing articles of clothing that had been contributed to the institution.

Hospital authorities announced that the structure will be remodeled. The plans for the building will not include any living space, it was stated. The upper floors will be leveled off and the basement and first floor will be used for the power plant and laundry.

St. Louis Adds Benefits; Enrolls County Subscribers

Three new benefits have been added to the service rendered by the Group Hospital Service of St. Louis, it has been announced. The new benefits include emergency room service in accident cases; fourteen days' care in general hospitals for illnesses previously excluded, such as tuberculosis and mental and nervous disorders, and all special medications and drugs required by the patient while he is in the hospital.

In addition to these benefits, the organization has recently taken steps to enroll an entire county in the plan. Through the sponsorship of the county medical society, the mayors of the respective cities in the county, the service clubs and the farm bureau, 900 out of 2700 eligible persons in Bates County, Missouri, have been enrolled as subscribers in the St. Louis plan.

DON'T PUT A POET ON YOUR STAFF!

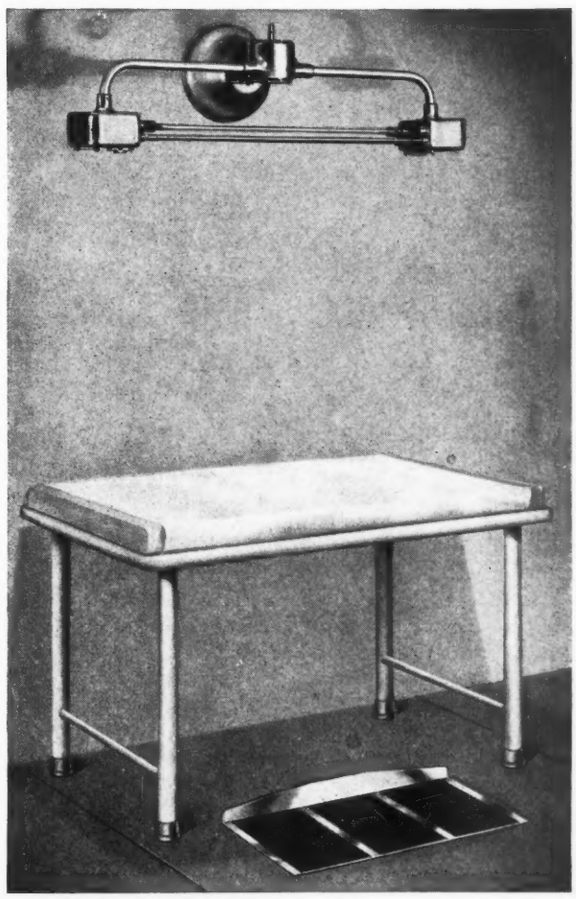
They are fine words, when he speaks of the pure air you breathe—but the scientist tells a different story! To him facts are facts, and cross infections in the nursery or children's ward almost prima facie evidence of the presence of air-borne pathogenic micro-organisms.

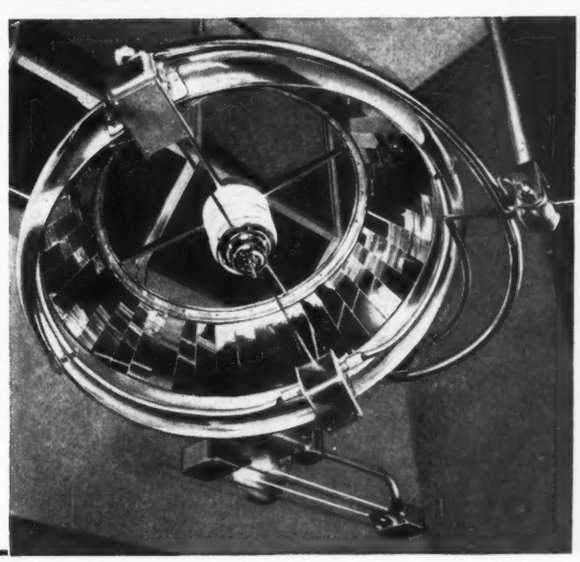
That's why so many progressive institutions are turning to Sterilamps* for protection. There are models to meet every requirement. The powder table, often a vulnerable point of common contact, is guarded by a Sterilamp which radiates constantly—until the nurse brings an infant there. Then the natural movement of stepping on the wide, flat floor switch temporarily shuts off the current and prevents direct exposure.

Sterilamps are made for installation in contagious wards, maternity rooms, receiving departments—indeed wherever good hospital practice and sound economics demand that potential contamination levels be reduced to a minimum.

This protection even extends to the surgery, where the Westinghouse Scialytic light, equipped with circular Sterilamps, combines in a single unit the most universally accepted shadowless surgical illumination with controlled bactericidal radiation.

Westinghouse Sterilamps are on display at the American Hospital Ass'n Meeting in Boston, Booth 252. We shall be glad to have you inspect this important contribution to better hospital service.





WESTINGHOUSE
X-RAY COMPANY, INC.
LONG ISLAND CITY NEW YORK

*The registered trade mark Sterilamp identifies a product of Westinghouse research

Dual System for Care of Indigent Sick Approved by New York Hospital Council

An exhaustive report on the use of tax funds to pay for the care of the indigent sick in the voluntary hospitals of New York City was published last month by the Hospital Council of Greater New York. The report was prepared by a special committee for the council consisting of Thomas D. Thacher, Adolf A. Berle and Luther Gulick.

The committee recommended that the dual system of caring for the indigent through the voluntary hospitals and the city owned hospitals be continued, that there be no expansion of the municipal hospital system to provide for patients who can be cared for in voluntary hospitals at less cost than the cost of such care in municipal hospitals and that the partnership that is implied in the present relationship of the voluntary and municipal hospitals be fully recognized.

To acknowledge this partnership, the voluntary hospitals were asked to relieve government of as large a burden of care of the poor as their capacity and resources may permit and as may be consistent with a high quality of service.

On the part of the city it was recommended that the compensation to the voluntary hospitals for the care of the needy should be in such amounts as will permit these institutions to operate their capacity on a sound basis, provided such compensation shall be less that the cost of caring for the same patients in municipal hospitals.

The committee recommended that the present per diem rate of payment be continued (with the exception of maternity cases in which the present flat rate for a 10 to 15 day stay was recommended) but that a careful study be made by a committee to recommend improvement in the present schedule.

Many inequities in the present schedule were noted by the committee. One quoted is as follows: "A child under 5 years of age admitted to a general hospital as an orthopedic emergency will be paid for at the rate of $1.15 per day. If he is more than 5 years of age, the general surgical rate of $3 will be paid. However, if the same child is admitted to an orthopedic hospital, the rate of $1.40 will apply until after he passes his sixteenth birthday, when the $3 rate will become effective."

The report suggested that the rate paid by the city should bear some consistent relation to the cost of care of patients. At present the rates are 49 per cent of the average direct operating cost in general medical and surgical hospitals, 76 per cent of cost in voluntary tuberculosis hospitals, 29 per cent in orthopedic hospitals, but 60 per cent in the convalescent branches of these hospitals.

"NO COMPLAINTS NOW ABOUT NOISE

. . . we used Sanacoustic in all noise-producing locations"

says: Miss Lois A. Roscoe, R. N.,

Superintendent of the Fort Hamilton Hospital, Hamilton, Ohio. (Miss Roscoe also used J-M Sanacoustic while Superintendent of the Olean, N. Y., General Hospital.)

Superintendent Roscoe has had wide experience with the irritating effect of noise on patients. She's found, as she expresses it, that "elimination of noise is one of the first requisites of a good hospital." And she knows a J-M Sound-Control Treatment assures the restful quiet that patients need . . . and at a cost well within hospital budgets.

Made expressly for hospital use, J-M Sound-Control Materials are completely sanitary to begin with . . . easy to keep sanitary. Painting or washing has no effect on their high sound-absorbing efficiency. Little upkeep is needed. And their light weight and simple erection method make installation rapid and economical.

Why not have a J-M Acoustical Engineer show you how inexpensively the noise problem can be solved in your hospital? No obligation, of course. Just write Johns-Manville, 22 East 40th Street, New York, N. Y.

CORRIDOR CLATTER can never annoy patients in the Fort Hamilton Hospital, Hamilton, Ohio. This is just one of the noise sources permanently silenced in this hospital by J-M Sound-Control Materials.

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A COMPLETE LINE OF ACOUSTICAL MATERIALS

PERMACOUSTIC . . . SANACOUSTIC . . . TRANSITE ACOUSTICAL UNITS

SPONGECOUSTIC . . . FIBRACOUSTIC . . . AIRACOUSTIC SHEETS

Quiz Program on Syphilis Sponsored by U.S.P.H.S. at New York World's Fair

More than 30,000 persons have ballotted in special information tests regarding syphilis and gonorrhea sponsored by the U. S. Public Health Service and the American Social Hygiene Association at the New York World's Fair, Surgeon General Thomas Parran announced recently. A quiz program conducted in the medical and public health building at the fair reveals that the public is particularly interested in the intravenous drip treatment for syphilis, known as the "five-day cure."

Measurement of the nation's "I.Q." about venereal diseases is now being compiled at the "Quiz Corner" and will be used by the Public Health Service to build a scientific program of individual and community education for the future.

WHEN STERILITY IS CONTAMINATION IS SEALED IN SEALED OUT

THE small glass ampule, hermetically sealed by fusion, is your assurance that its contents are protected from contamination and deterioration. Nothing can pass through *that* seal — and you use the ampule with confidence. ¶ Now, picture that small ampule enlarged a thousandfold — that is the STERISOL ampule of dextrose and saline solutions for intravenous use, for hypodermoclysis. Solutions prepared with more exacting care and control than normally necessary, *pyrogen free,* and protected in the Pyrex glass ampule, sealed by fusion, a closure that cannot work loose, cannot admit air, and assures absolute airtight protection until opened. ¶ This protection is available to hospitals at moderate cost. Let us send you a booklet that describes the Sterisol process of supplying *safe* liquids for hospital use.

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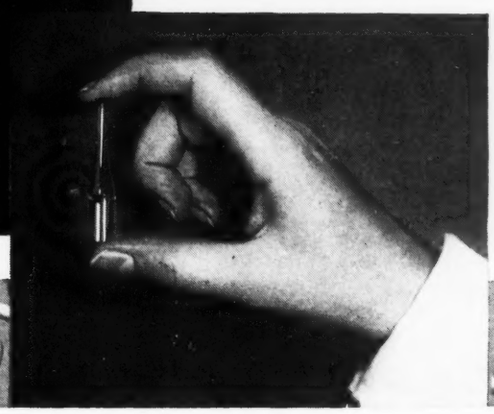
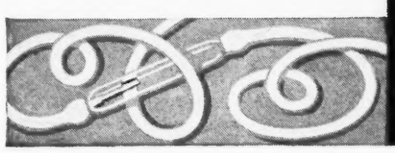
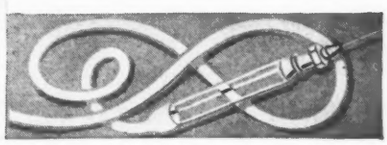
NEW YORK **ST. LOUIS**







Fool You When Buying

FLOOR TREATMENTS

IT'S an old, old story . . . the best is usually cheapest in the long run. Never were truer words spoken about floor treatments. Take the case, for example, of the building superintendent* who found to his surprise that it actually cost *less* to pay *more* for floor treatments.

Here is why: The nationally known floor wax he had formerly used cost considerably less per gallon than Car-Na-Lac . . . but required *twice* the number of applications. As a result, today this superintendent's floor maintenance figures show that Car-Na-Lac's more durable finish is netting him a saving of 13% per month in material costs . . . plus 50% in labor!

**Name on request*

CAR-NA-LAC
LACQUER-LIKE FLOOR FINISH

is radically different from all other self-polishing floor treatments. Easily applied with mop or cloth, it goes on like lacquer . . . leveling itself out to a brilliant, streakless luster. Dries like wax in less than 30 minutes . . . requires no buffing. Car-Na-Lac may be used on any smooth, sealed or fairly non-porous floor. Worn traffic lanes are easily repaired without showing overlaps . . . it is non-slippery, WATERPROOF. Car-Na-Lac outwears competitive waxes several times—in one case 5 to 1. Covers 1,500 to 2,000 sq. ft. per gallon.

FREE BOOK!

Not mere sales propaganda . . . but a handy book of practical "do's" and "don'ts" by floor maintenance experts. Write for copy today. No obligation involved.

Free Demonstration On Your Own Floors

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Dietitians Will Discuss Personnel, Cost Control at New York Convention

The twenty-third annual meeting of the American Dietetic Association will convene on October 20 at the Pennsylvania Hotel in New York City. The meeting will continue until October 24.

At the opening session on Monday morning Dr. Eugene F. DuBois, professor of clinical medicine, Cornell University, will address the delegates on the subject of "Fewer and Better Diets." Monday evening will be devoted to a symposium on personnel. Among the speakers will be Elizabeth Rugh, dietitian, Veterans Administration Facility, The Bronx, N. Y., who will discuss "Our Responsibility to the New Employe," and Alta B. Atkinson, dietitian, New York Hospital, New York, whose topic will be "Safety Education."

New officers will be elected at the general business meeting on Tuesday afternoon.

At the section on food cost control on Wednesday morning, Mary M. Harrington, Harper Hospital, Detroit, is scheduled to speak on the pay type of cafeteria. The Wednesday afternoon meeting will be a general session at which committee chairmen will report on the progress made on the various studies that were undertaken throughout the year. At this meeting Mary Northrop, Kings County Hospital, Seattle, Wash., and Sister Jeanne d'Arc, Fontbonne College, St. Louis, will report on a glossary of terms used in dietetics.

Of particular interest to hospital dietitians should be the talk on "New Ideas in Food Service Equipment," to be given on Thursday morning by Owen T. Webber, consultant in problems on group feeding, Weehawken, N. J.

In addition to the regular meetings, clinics will be held in various hospitals in New York on Thursday and Friday.

Hospital Insurance Plan Proposal to Aid Indigents in Hillsdale County, Mich.

A country-wide plan of hospital care insurance at low fees is being set up in Hillsdale County, Michigan, under the leadership of the Hillsdale chamber of commerce and the most prominent citizens of the county and with the backing and advice of the W. K. Kellogg Foundation at Battle Creek, Mich.

Graham L. Davis, consultant on hospitals of the foundation, has suggested that the entire county be considered as a unit and that fees be set at 10 cents a week for an individual, 20 cents for a couple and 25 cents for an entire family. Hospitalization would be in ward beds for 21 days per year. Subscribers or their dependents desiring private or semiprivate rooms could obtain them by paying the difference between their allowance and $3.50 per day.

The county board of supervisors in Hillsdale County is considering a proposal to take out this coverage for all indigent persons in the county. The county social welfare board believes that the plan will make it possible for about 50 per cent of those who now receive hospitalization at public expense to pay their own way.

If the plan works in Hillsdale County it will probably be extended to adjoining counties that are part of the foundation's demonstration area.

Training for Hospital Librarians

The University of Minnesota is scheduling a course in hospital librarianship in the spring quarter of 1941. It is to be given with the cooperation of the Minnesota State Department of Social Security. The curriculum will include lectures, discussions, reports and observations, together with a six weeks' period of practice or internship in selected institutions.

Coming Meetings

Aug. 28-Sept. 11—Chicago Institute for Hospital Administrators, University of Chicago.

Sept. 2-14—New England Institute for Hospital Administrators, Harvard Medical School, Cambridge, Mass.

Sept. 2-6—American Congress of Physical Therapy, Hotel Statler, Cleveland.

Sept. 14-15—American Protestant Hospital Association, Boston.

Sept. 15-16—American College of Hospital Administrators, Hotel Statler, Boston.

Sept. 16-20—American Hospital Association, Hotel Statler, Boston.

Oct. 8-11—American Public Health Association, Book-Cadillac Hotel, Detroit.

Oct. 20-24—American Dietetic Association, Hotel Pennsylvania, New York.

Oct. 21-24—American College of Surgeons, Hospital Standardization Conference, Hotel Stevens, Chicago.

Oct. 21-25—American Association of Medical Record Librarians, Congress Hotel, Chicago.

Oct. 21-Nov. 1—Southern Institute for Hospital Administrators, Tulane University, New Orleans.

Nov. 8-9—Kansas State Hospital Association, Lamer Hotel, Salina.

Nov. 13—Colorado Hospital Association, Denver.

Dec. 5—Utah State Hospital Association, Salt Lake City.

Feb. 26—Texas Catholic Hospital Conference, Galveston, Tex.

Feb. 27-March 1—Texas Hospital Association, Galveston, Tex.

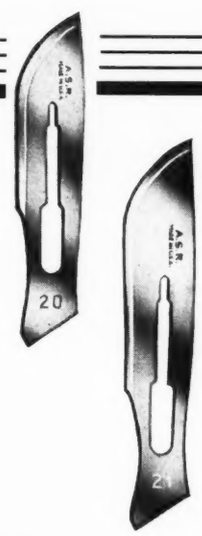
March 3-6—Association of Western Hospitals, Fairmont Hotel, San Francisco.

March 12-14—New England Hospital Assembly, Hotel Statler, Boston.

April 21-23—Iowa State Hospital Association.

April 24-25—Mid-West Hospital Association, Kansas City.

PREVENT NERVE-WRACKING DISTURBANCES IN THE OPERATING ROOM



Surgeon's blades represent a very minor part of the cost of operating equipment. Yet, on them, the reputation of the operating room depends to a considerable extent. Dull blades irritate the surgeon and may even hamper him severely. A. S. R. Surgeon's Blades were developed primarily to offer the surgeon a blade that is uniformly keen. No variation in these blades can be detected by the most sensitive hand. A. S. R. Surgeon's Blades are available in 9 standard types to fit new and old surgical handles.

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SURGEON'S BLADES
and Handles

Medical Care Can Be Given for $30 per Year, Study of Group Plan Reveals

Complete medical care of good quality can now be obtained at a cost of $20 or $30 per person per year, or less, through voluntary health insurance plans that utilize the medical advantages and the financial economies of group medical practice.

This is the conclusion of a report by Dr. Franz Goldmann, associate clinical professor of public health of Yale University, just published by the Joint Committee of the Twentieth Century Fund and the Good Will Fund. These funds supported Doctor Goldmann's study, made by personal visits to five organized plans of medical care in widely separated parts of this country.

In all the plans a group of physicians, organized as the staff of a hospital or a clinic, provides medical care to a group of members or subscribers and their families. None of these groups has its own hospital, arrangements being made with one or more institutions in the locality.

The members of these plans are in some cases industrial wage earners; in others, they are "white collar" workers. The range of cost to the members is from less than $12 annually in one plan to as high as $30 in another. The plans with large membership, from 10,000 to 50,000, show lower costs, although the differences in cost also vary with the scope of medical care offered and with the characteristics of the membership.

The most complete plan, which provides all physicians' services, including specialists, hospital care, medicines, nursing and considerable dentistry, has 51,000 members and their dependents, and costs less than $22 per person annually.

Economies are brought about because the physicians utilize the advantages of group practice, with joint offices and joint use of equipment, and with an organized staff of nurses, laboratory technicians and others to assist them, the report points out. The physicians in these plans are paid salaries, the minimum being from $3000 to $3500, paid only to a small number of physicians in assistant positions, and running up to $7200 and $10,000 for experienced physicians in positions of responsibility.

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. . . give your staff the best
Germa-Medica and Levernier Dispensers are professionally correct
WHEN YOU INSTALL Germa-Medica and Levernier dispensers in your scrub up rooms, you win the favor of every doctor on your staff. Just one scrub up tells doctors that here is a combination in a class by itself.
Such soothing, instant lather . . . such thorough-cleansing action . . . such perfect precision by the Levernier dispensers, all give doctors the feeling that you're doing your best to give them the best that money can buy.
Will doctors appreciate your efforts? We know that wherever Germa-Medica is used, they do express their gratitude.
Levernier dispensers are professionally correct. Unlike other dispensers, they are easily, completely sterilized.
Switch to Germa-Medica and Levernier dispensers. Write for details — today.
The HUNTINGTON LABORATORIES Inc
HUNTINGTON INDIANA
GERMA-MEDICA
AMERICA'S FAVORITE SURGICAL SOAP

To Build Wing for Mental Patients

Construction work has been started on a new unit for St. Luke's Hospital, Spokane, Wash., to replace the old west wing of the hospital. The new structure, which will house mental patients, will be called Shadle Memorial Department of Special Medicine and was made possible by a gift from Mr. and Mrs. Eugene A. Shadle of Spokane. The first floor of the building is designed for the care of acutely disturbed men and women patients and the second and third floors will house mildly disturbed and senile patients. An ingenious system of locks has been installed to prevent patients from escaping; detention windows obviate the need for grilles and bars.

New Children's Department Equipped

Butler County Memorial Hospital, Butler, Pa., is reequipping and refurnishing as a children's ward a department that has not been used heretofore. The new unit will include private, semiprivate and ward accommodations for infants and children under 12 years of age. The ward from which the children are being moved will be remodeled to provide additional facilities for adult patients.

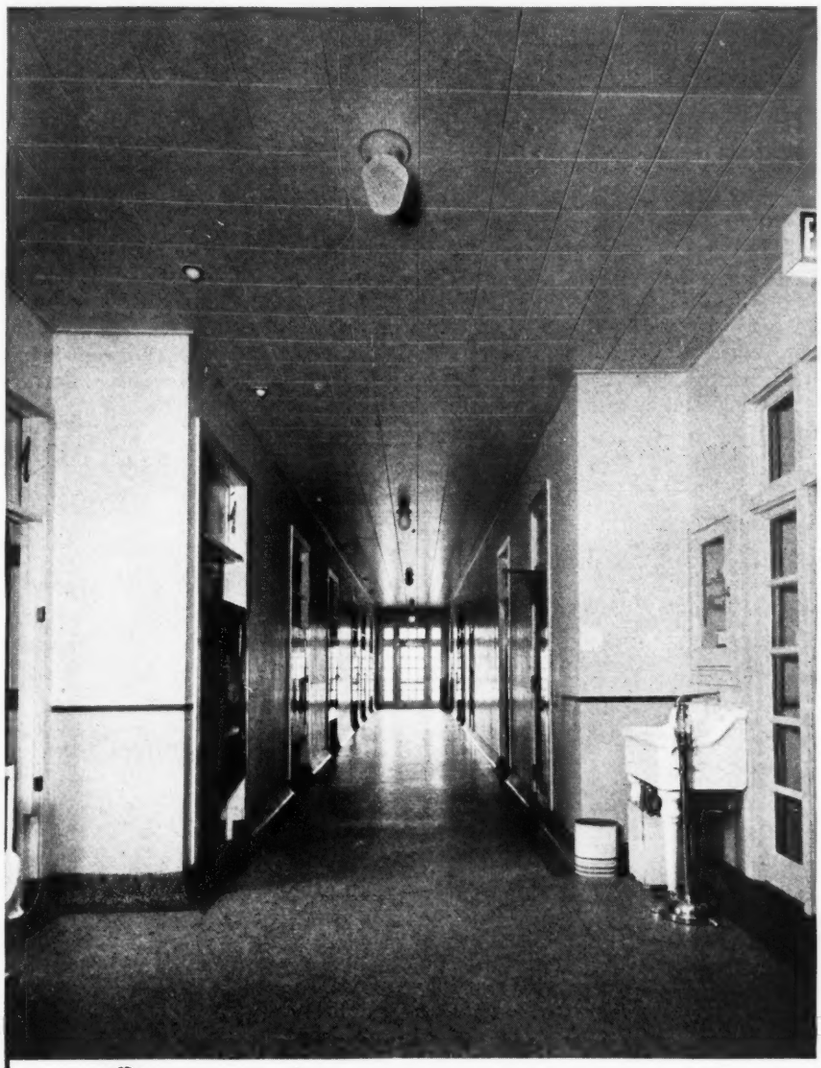
Superintendent's Son Killed

Pilot Officer Duncan Hewitt, son of Dr. and Mrs. S. R. D. Hewitt of Saint John, N. B, was killed in action recently. Pilot Officer Hewitt had been in London studying aeronautics when the war broke out and enlisted in the Royal Flying Corps. His father is superintendent of St. John General Hospital.

BECAUSE ACOUSTI-CELOTEX* IS PERMANENT . . .

ACOUSTICALLY EFFICIENT AFTER REPEATED PAINTINGS

IT APPEALS TO THRIFTY HOSPITAL AUTHORITIES . . .



Here is a corridor of the Epworth Hospital, South Bend, Indiana. Acousti-Celotex has been used to give it permanent acoustical efficiency—*to subdue voices and hush the sound of footsteps.* And why did the Epworth authorities select Acousti-Celotex?

For the same reasons that this proved material has been the choice of hundreds of other hospitals: Hospital walls and ceilings must be painted often, and *repeated paintings do not impair the acoustical efficiency* of Acousti-Celotex. Moreover, Acousti-Celotex can be applied right over old plaster, in a short time, at moderate cost.

Let a Celotex acoustical distributor make a FREE Noise Survey of your hospital and show you, *without obligation,* how thrifty this famous sound-conditioning method really is. Mail the coupon!

**The word Acousti-Celotex is a brand name identifying a patented perforated acoustical fibre tile marketed by The Celotex Corporation.*

APPROVED AMERICAN COLLEGE OF SURGEONS

Acousti-Celotex in corridor ceiling of Epworth Hospital, South Bend, Indiana, says "Hush" to unavoidable hospital noise.

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Please have a Celotex Acoustical Distributor see me about a FREE Noise Survey of our hospital. Also send your valuable booklet, "NOISE," and your magazine, "QUIET FORUM."

Name .....

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City .....

County ..... *State* .....

Plan for Surgical Care Set Up by Pittsburgh Hospital Service Group

A surgical benefit plan in connection with hospital care insurance was announced last month by the Hospital Service Association of Pittsburgh, which serves western Pennsylvania. This benefit will be provided by the Medical Service Association of Pennsylvania, of which Dr. C. L. Palmer is president, but will be sold by the Hospital Service Association.

Rates for the surgical benefit are 35 cents, $1.05 and $1.75 per month for individuals, couples and families, respectively. Obstetrical service is available under the family plan only.

The surgeon's bill is to be paid directly by the Medical Service Association. Free choice of participating surgeons may be made by the subscriber, as is the case in choosing hospitals. Persons who have surgical coverage will be eligible for benefits when they are away from home, regardless of the place or distance. No physical examination will be required but an upper income limit is being set. This figure varies according to the number of the subscriber's dependents.

The Hospital Service Association also celebrated last month the enrollment of 250,000 members, a rapid growth in slightly more than two and one half years. The enrollment for the first seven months of 1940 equaled that for the entire year of 1939.

Geisinger Adds Diagnostic Unit

The George F. Geisinger Memorial Hospital, Danville, Pa., has begun the construction of a new three story diagnostic building. The ground floor will contain a large central surgical supply room. The department of internal medicine will occupy most of the first floor, while the second floor will contain a fracture room, operating room facilities and new treatment rooms for the department of urology. It is expected that the new unit will be ready for occupancy by December of this year.

Michigan Plan Changes Name

The Michigan Society for Group Hospitalization was granted permission by state officials to change its name to "Michigan Hospital Service," effective August 1. The simplified name was adopted for the convenience of subscribers and to conform with the name of Michigan Medical Service, the nonprofit plan for medical and surgical care sponsored by Michigan physicians.

Boston's Marine Hospital Has Large Auditorium

The new marine hospital at Boston was dedicated in June. It is on a site of 13 acres on Warren Street near Commonwealth Avenue. The architecture is modified Georgian in style and the building is of red brick and brown limestone construction. The bed capacity is 360.

A feature of the main building is an auditorium with a seating capacity of 300. The auditorium is acoustically treated and has a stage and dressing room facilities. It will be used for medical meetings and for the recreation and entertainment of ambulant patients.

Hospital Corporations Merged

The Lakeside Hospital, Maternity Hospital, Babies' and Children's Hospital and the University Hospitals of Cleveland recently consolidated their corporate affairs and will operate as one corporation. For general purposes the institution will be referred to as the University Hospitals of Cleveland. The new organization will also operate the Rainbow Hospital for Crippled and Convalescent Children under the terms of a contract entered into with the board of trustees of that hospital.

WINDOWS THAT OFFER "True Hospital-ity"

St. John's Hospital, Springfield, Ill., Henry R. Helmle, Architect; J. L. Simmons Co., Inc., Contractor

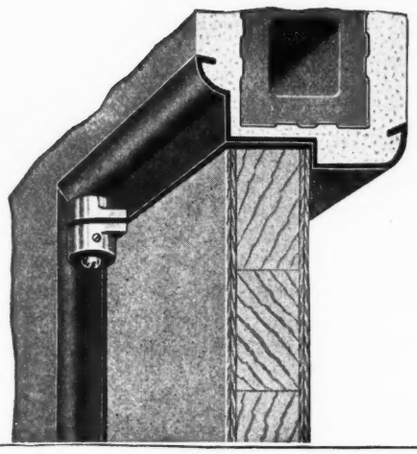
This cheery room in St. John's Hospital, Springfield, Ill., is an example of the results that are assured when Fenestra Steel Screened FENMARK Windows are used. There are 10 important features which prove the superiority of these better steel windows.

1. Increased Beauty—the result of attractive lines and well-proportioned glass areas.
2. More Daylight—is assured by larger glass areas with slender steel frames and muntins.
3. Better Ventilation—100% opening if desired... twice the opening of double-hung windows. Projected-in ventilators at sill are built-in wind guards which protect against drafts.
4. Easy Opening—Vents always open easily, silently... never warp, swell, stick or bind.
5. Safe Washing—glass is washed on both sides safely from inside.
6. Superior Weather-tightness—vents close snug-tight against storms and winter weather.
7. Better Screens.
8. Added Fire Safety.
9. Reduced Maintenance.
10. Low First Cost.

For complete details, telephone the local Fenestra Office (in all principal cities) or write—Detroit Steel Products Company, 2255 East Grand Boulevard, Detroit, Michigan.

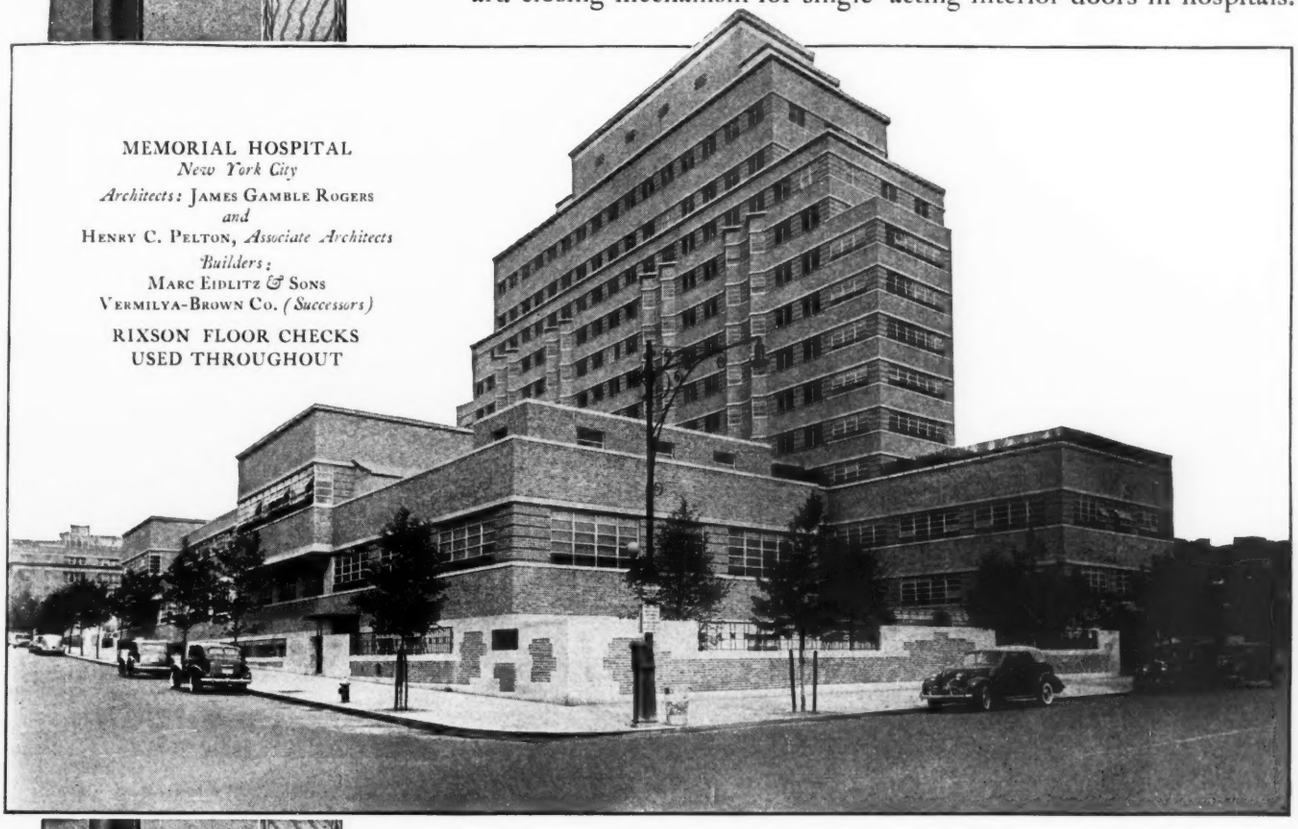
SEE FENESTRA EXHIBIT AT AMERICAN HOSPITAL ASSOCIATION CONVENTION, BOSTON, IN SEPTEMBER.

Fenestra MODERN HOSPITAL WINDOWS



WHAT Well-Tailored Doors ARE WEARING THIS YEAR

● To give doors that "tailored", clean-cut appearance—not as a matter of fashion, but of clean-cut *functional design*—That's how architects are arriving at **RIXSON Uni-Check** as the standard closing mechanism for single-acting interior doors in hospitals.



MEMORIAL HOSPITAL
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Architects: JAMES GAMBLE ROGERS
and
HENRY C. PELTON, *Associate Architects*
Builders:
MARC EIDLITZ & SONS
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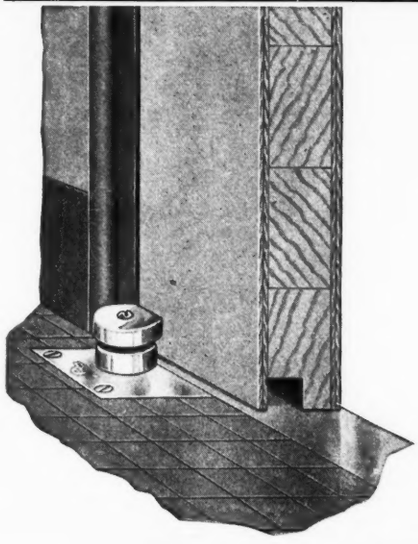
RIXSON FLOOR CHECKS
USED THROUGHOUT



The absence of protruding arms, hangers, housings—in fact, anything to break the clean sweep of walls and doors—is a relief to the eye. But, functionally, the **Uni-Check**, at a cost that competes with any other type of check, provides automatic quiet closing—eliminates hard-to-clean or dust catching surfaces—offers no obstruction to mops, dust cloths or paint brush... All good features for the hospital.

RIXSON Uni-Checks are ideal not only for hospital use but excellent wherever self-closing interior doors are a convenience or necessity. Full information available on request. Complete catalog information is on file with most architects. SPECIFY RIXSON UNI-CHECK FOR ALL INTERIOR SINGLE ACTING DOORS THAT HAVE TO BE SELF-CLOSING.

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RIXSON *Uni-Check*

Complete New Unit at King's Park

Completion of the 11 story building for infirm patients in the Kings Park State Hospital group at Kings Park, Long Island, has been announced by Dr. William J. Tiffany, commissioner of the New York State Department of Mental Hygiene. The new building is of steel and concrete construction with brick facing and was erected at a cost of $1,863,390. Each floor has its own treatment rooms, bath sections, beauty parlor or barber shop, clothing rooms, isolation section, single rooms, wards and other accessory units. The building conforms to the state practice of construction for a 75 to 100 year occupancy.

New York Sets Wage Minimum

An order by the minimum wage division of the State Department of Labor of New York has set wages in laundries at $14 per week for a week of not more than 40 hours and a minimum of 35 cents per hour for less than 40 hours. The maximum work week is set at 48 hours with the first five hours beyond 40 at 35 cents per hour and the remaining three hours at 52½ cents per hour. No laundry employe is to work more than 48 hours. Credit for perquisites is to be allowed per week as follows: three meals daily, $3.50; room, $1.50.

Nonprofit Hospital Plans Report Gains in Past Year

The total enrollment of the 59 approved nonprofit hospital service plans on July 1 was 5,200,000 persons, according to information compiled by the Commission on Hospital Service. The Cleveland Hospital Service Association, with a reported membership of 356,000, forged into second place, its membership for the first time exceeding that of the Minnesota plan, which stood at 343,000. The New York plan, even though its membership dropped 40,000 during the quarter, remained the largest plan in the country with 1,276,000 subscribers.

The plans that gained 10,000 subscribers or more during the quarter with the amount of gain are as follows: Cleveland, 52,000; Michigan, 47,000; Cincinnati, 29,000; Pittsburgh, 28,000; New Jersey, 24,000; Philadelphia, 23,000; St. Louis and Buffalo, 16,000, each; New Haven, Conn., 14,000; Chicago, 13,000, and Boston and Minnesota, 12,000, each.

Practically every plan in the country made some gain in membership. The total gain for all plans during the quarter was 377,000 subscribers. This is a gain at the rate of about 1,500,000 subscribers per year. If plans continue to grow as they have since 1936, 10,000,000 will be enrolled by January 1943.

Red Cross to Enroll Blood Donors

Acting at the request of the surgeon general of the Army, the American Red Cross is planning to enroll a nation-wide corps of volunteer blood donors which would become part of the national defense program, when and if needed. For the last four years, 12 Red Cross chapters have been furnishing whole blood from volunteers to hospitals for civilian use. The new program will be patterned along similar lines but plasma will be used instead of whole blood. A preliminary study involving 1300 volunteers in four cities is to be conducted under the direction of a special committee.

Health Preparedness Program

Dr. Thomas Parran, surgeon general of the U. S. Public Health Service, has been named coordinator of medical and health preparedness for national defense, according to an announcement by the National Defense Commission. Doctor Parran is one of four members of the committee that has been established to coordinate the health and public welfare efforts of four governmental agencies. The work of the committee will emphasize the importance of maintaining and improving standards of health and welfare to the end that citizens may be physically prepared for their responsibilities.

ONE OF THE INTERESTING ITEMS AT THE CONVENTION

One of the leaders of the many items of interest offered at the A. H. A. Convention, is this efficient cast iron Acid-Resisting enameled Patient's Bath, seen at Booth 513. Waist high rim, and open on three sides, it is particularly appreciated by nurse and attendant. Large spout and drain and spray fitting, allow quick filling and emptying and full bathing facilities. Remember this: In the complete line of "Standard" Plumbing Fixtures there are products of all types to meet every Hospital need. Write today for full information.

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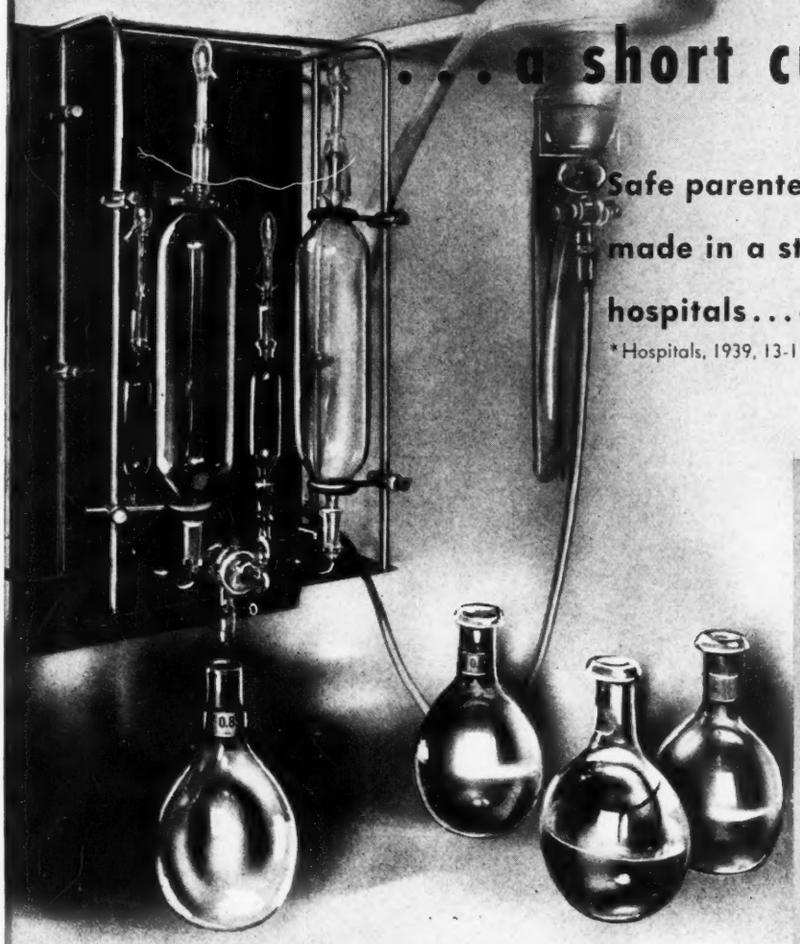
HP13146 – Patient's Bath on high base, made of "Standard" Acid Resisting Enamel on cast iron.

Visit our building at the New York World's Fair. Ask for Mr. Frank Stubbs, our Exhibit Manager.

★ ★ DEFEND OUR COUNTRY. ENLIST NOW IN THE U. S. ARMY OR NAVY ★ ★

THE FENWAL TECHNIC

. . . a short cut to cost cuts



Safe parenteral fluids can, and are being made in a steadily increasing number of hospitals . . . and at tremendous savings.*

*Hospitals, 1939, 13-11:84

The distinctive contour of Fenwal container-dispensers insure negligible breakage during sterilization. When removed from sterilizer they will not collapse when subjected to sudden atmospheric influences or rapid temperature change.

Fenwal System installations are timely. There are no delayed delivery problems . . . no apprehension regarding freshness, sterility or proper tagging of stock. Fenwal container-dispensers and TEL-O-SEAL hermetic closures can be re-used hundreds of times.

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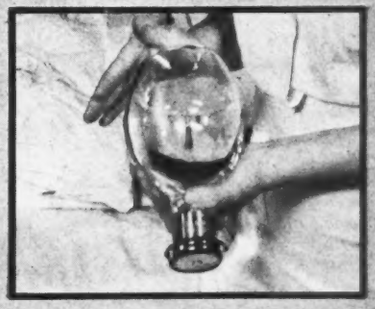

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The audible water-hammer signal instantly indicates that hermetic seal has not been broken.

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THE SOLUTION DESIRED AT THE INSTANT REQUIRED

Names in the News

Administrators

DR. GEORGE F. STEPHENS, for twenty-one years the superintendent of Winnipeg General Hospital, Winnipeg, Ontario, has resigned to accept the position of director of the Royal Victoria Hospital, Montreal. He assumed his new duties on August 1. Doctor Stephens was president of the American Hospital Association in 1932 and has served as president of the Canadian Hospital Council for several years. He is a member of the editorial board of THE MODERN HOSPITAL. The retiring superintendent of the Royal Victoria Hospital, W. R. CHENOWETH, has been in poor health for some time.

DR. JOHN J. RANDALL, superintendent of Pawling Sanatorium, Wynantskill, N. Y., has been appointed a member of the staff of the Samaritan Hospital, Troy, N. Y., and will head the new tuberculosis and chest diagnostic department that will be opened early in the fall. Doctor Randall will continue his duties as head of the sanatorium.

DR. M. W. FOSTER has been named superintendent of Huey P. Long State Charity Hospital, Pineville, La., to succeed DR. OSYMN MCFARLAND, who resigned recently.

DR. WILLIAM T. CLARK has been given the position of assistant superintendent and educational director of Meyer Memorial Hospital, Buffalo, N. Y.

P. M. HUTCHINSON has been appointed to the position of assistant administrator of Polk County Public Hospital, Des Moines, Iowa. Mr. Hutchinson was formerly assistant secretary and treasurer of the American Board of Internal Medicine.

DR. HERBERT T. WAGNER, former assistant director of Roosevelt Hospital, New York, has been named head of Stuart Circle Hospital, Richmond, Va. He succeeds CHARLOTTE PFEIFFER, who resigned recently. KATHERINE GARY, a former instructor in the hospital's school of nursing, was appointed superintendent of nurses and head of the nurses' training school, a position which Miss Pfeiffer had held in conjunction with the superintendency.

MARY E. MONGEAU, R.N., superintendent of Webster District Hospital, Webster, Mass., since 1938, resigned August 1 to become head of Noble Hospital, Westfield, Mass. She succeeds MARGARET SMYLIE, who is retiring from hospital work.

HERMAN J. GRIMMER JR., administrative assistant of New Rochelle Hospital, New Rochelle, N. Y., has accepted the post of administrator of the new Gulf Oil Corporation Hospital now under construction at San Tome, Venezuela. Mr. Grimmer is a graduate of the school of nursing of Worcester City Hospital, Worcester, Mass., and served as administrative assistant in that institution for several years.

MAUD ESSIG, R.N., superintendent of the Brokaw Hospital, Normal, Ill., resigned recently. For fourteen years Miss Essig held the position of superintendent of nurses and for the last two years she has combined that post with that of superintendent of the hospital. Prior to her association with Brokaw Hospital, she was superintendent of the Elkhart General Hospital, Elkhart, Ind.

Spring Air
TRADE MARK REG. U.S. PAT. OFFICE
MATTRESS

It isn't by luck that Spring-Air is the favorite mattress among Hospitals. It's because Spring-Air is the only mattress to give

All Four VITAL VALUES

GET ALL THE FACTS
SPRING-AIR COMPANY
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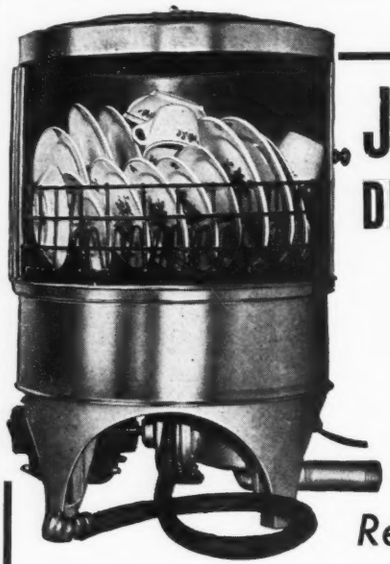

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Ideally Adapted to Hospital Requirements

Compact enough for use in diet kitchens; yet sufficient capacity for main kitchen jobs where two hundred meals are served. Efficient, economical, with many unique and desirable advantages. Outstanding superiority in cleaning glasses and silverware—therefore an ideal auxiliary for this special purpose in large institutions.

Write today for complete descriptive folder. No obligation. Requests for demonstrations invited.

See our display in Chicago at the National Restaurant Association Convention, October 7-11.

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3 QUESTIONS

and EIGHT ANSWERS . . . *you'll find interesting*

THESE ARE TRUE FACTS . . . AREN'T THEY, DOCTOR?

You regard the responsibility placed upon you and the character of the equipment in your surgery as a sacred trust.

You realize that each patient comes to you in full faith and confidence believing that your surgery is properly equipped to assure his safety during the operation and post-operatively.

You are sincere in your desire to be worthy of the confidence and trust reposed in you and your institution.

You know that in both major and minor operations, the recovery of the patient is, to an important degree, dependent upon the scientific administration of anesthesia.

THEN, THESE FACTS ARE IMPORTANT . . . AREN'T THEY, DOCTOR?

Leading surgeons and hospitals recognize the HEIDBRINK KINET-O-METER as **the standard of excellence.**

It is scientifically correct, safe, simple in operation and economical . . . built to exceed the requirements of all anesthestists.

There are no concealed rubber bags, diaphragms or other perishable parts to control gas pressure and flow. No freezing, no filling, no sediment, no cleaning.

Its accurate, trouble-free DRY FLOAT Flow Meters assure positive and easily controlled administration . . . and your surgeons can proceed with confidence in the knowledge that the HEIDBRINK KINET-O-METER is safe for the patient and for them . . . worthy of the faith and trust reposed in it.

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AVAILABLE IN CART, CABINET AND STAND MODELS

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Please send me more detailed information on Heidbrink Kinet-O-Meter and Ohio Gases.

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Dr. Joseph S. Skobba, formerly a member of the medical staff of Central State Hospital, Indianapolis, has been named head of the Muscatatuck Colony for Feeble Minded at Butlerville, Ind. Doctor Skobba succeeds Dr. George Denny, who resigned because of ill health.

Jean Cruickshank, superintendent of Theda Clark Memorial Hospital, Neenah, Wis., is retiring on September 1 after fourteen years of service as head of the institution.

Dr. Willard L. Quennell terminates twenty years of service as superintendent of Highland Park General Hospital, Highland Park, Mich., on September 1 to become superintendent of the Norfolk General Hospital, Norfolk, Va., succeeding Dr. Arthur H. Perkins.

Lillian A. Guillod, R.N., superintendent of the Convalescent Home of Children's Hospital, Wellesley Hills, Mass., retired recently after twenty-two years as head of the home. She has been succeeded by Marion C. Burns, R.N., of Boston, who served as head nurse of the home from 1926 to 1928.

Alfred T. Geddes of New Haven, Conn., has been appointed director of cottage life at the new State Training School and Hospital for the Feeble Minded, Southbury, Conn. Prior to his appointment, Mr. Geddes was physical education director of Danbury Teachers College, Danbury, Conn.

Department Heads

Mrs. Gladys Ewan has been appointed housekeeper of the Children's Country Home, Westfield, N. J. Mrs. Ewan formerly was assistant housekeeper at Beth Moses Hospital, Brooklyn, N. Y.

Elizabeth A. Gunn has resigned as executive housekeeper of the United Hospital, Port Chester, N. Y., to assume a similar post at Vassar Brothers Hospital, Poughkeepsie, N. Y. Miss Gunn's successor is Martha Ellis. Miss Ellis was formerly nursing supervisor at Grasslands Hospital, Valhalla, N. Y.

Edna M. Beyrer, assistant superintendent of nurses at Fort Sam Houston Station Hospital, San Antonio, Texas, was retired on July 31.

Lena R. Oakley has been appointed principal of the school of nursing of the Methodist Hospital, Brooklyn, N. Y. Miss Oakley fills the position left vacant by the resignation of Ruth B. Wood.

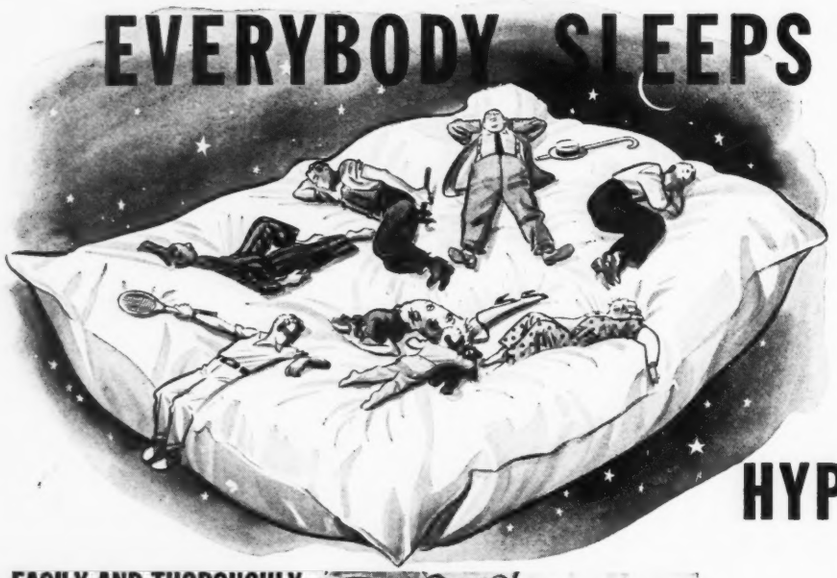
E. Margaret Frost, formerly assistant superintendent of nursing at Newport Hospital, Newport, R. I., has been named superintendent of nursing at Memorial Hospital, Pawtucket, R. I., to succeed Madeleine M. Schroeder. Miss Frost was graduated from Queen's Hospital, University of Birmingham, England.

Laura R. Logan, R.N., has resigned the position of superintendent of nurses at Boston City Hospital, Boston. Her resignation climaxed a three year controversy with the Boston city council. She has been given a leave of absence until fall when her resignation will become effective. Margaret Busche, Miss Logan's assistant, has been named acting superintendent of nurses. Miss Logan was formerly superintendent of nurses at Cook County Hospital, Chicago.

Josephine Gilbert, R.N., assistant director of the nurses' training school of St. Luke's Hospital, Chicago, recently resumed her duties there after a year's leave of absence. During the past year Miss Gilbert attended Columbia University, New York, and obtained her degree in nursing education.

Deaths

Minnie Dunn, assistant superintendent of nurses at Massachusetts State Hospital and Infirmary, Tewksbury, Mass., died suddenly July 11. Miss Dunn had been associated with the hospital since 1907 and had served as assistant superintendent of nurses for the last fifteen years.



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U.S. ROYAL FOAM

Pillow

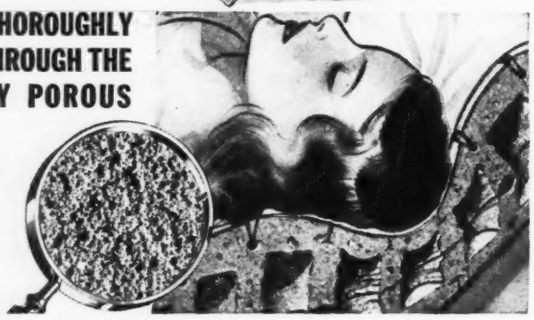
. . . but doctors and hospitals are especially interested in its unusual

HYPO-ALLERGENIC

Quality!

EASILY AND THOROUGHLY STERILIZED THROUGH THE COMPLETELY POROUS TEXTURE.

WASHABLE!



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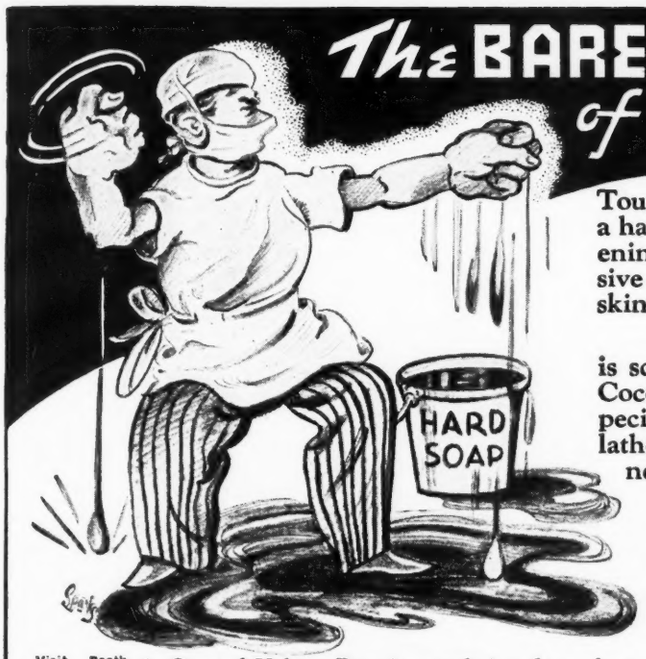
MISHAWAKA, INDIANA

The BARE KNUCKLE Champ of the OPERATING ROOM—



Tough hands may be a help in prize fighting — but they're a handicap to skilled surgery. Take no chances of deadening that delicate sense of touch. Avoid harsh or abrasive scrub-up soaps that might irritate or toughen the skin. Insist on SEPTISOL.

Septisol Surgical Soap

is scientifically prepared from pure Olive Oil, Cochin Cocoanut Oil, and other fine vegetable oils. Made especially for scrub-up rooms. Gives a thick, creamy lather. Helps eliminate danger of infection and roughness that comes from use of harsh, irritating soaps.

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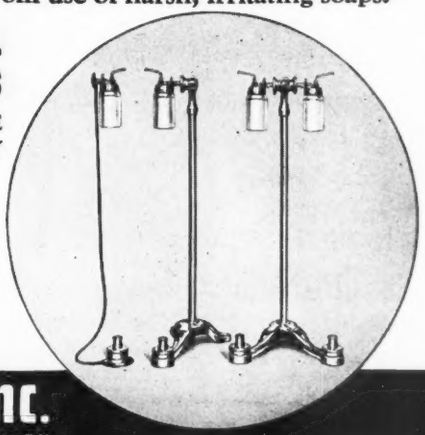
CONVENIENCE *Plus* ECONOMY



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1. Control Valve — Permits regulating flow of soap from few drops to full ounce. Eliminates waste.
2. No dripping. No hardening. Unused soap flows back into receptacle. Safe — sanitary.
3. Spout swings from left to right. Puts soap where you want it. Spout is removable for easy filling.
4. Air Intake Valve. Foot operated--pneumatic pressure does the work

Septisol Dispensers are furnished in three models — Double Portable, Single Portable and Wall Type.

VESTAL CHEMICAL LABORATORIES, INC.

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IN HOSPITALS AND INSTITUTIONS FROM COAST TO COAST

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U. S. ROYAL FOAM MATTRESSES

"U. S. Royal Foam is ideal for allergic patients."
DOCTOR
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"I have fewer 'bed cranks' — patients are more relaxed."
HOUSE-KEEPER
"So clean—so easy to sterilize."
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"I like the Economy of U. S. Royal Foam."
"Fewer pressure sores with U. S. Royal Foam."
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U. S. ROYAL FOAM MATTRESS

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MOLDED IN ONE PIECE
of pure, odorless latex foam

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UNITED STATES RUBBER COMPANY • MISHAWAKA, INDIANA

Trade News

Stainless Steel Furniture

• The Simmons Company, Chicago, is announcing a completely new line of stainless steel furniture for hospitals. Among the new items (some of which will be exhibited in Boston) are instrument tables, examining tables, stands, chairs, overbed tables and beds.

Ultraviolet Lamp

• A new lamp, especially designed for local application of ultraviolet irradiation, that incorporates a new principle of cooling has recently been put on the market by the Hanovia Chemical & Manufacturing Co., Newark, N. J. It is to be shown at the A.H.A. convention in Boston.

Emergency Lighting

• A new emergency lighting unit lately added to the line of Triumph Explosives, Inc., Elkton, Md., consists of a panel fastened to the wall and connected by wire to a light suspended in a room where illumination would be required in an emergency. The panel contains a radium dial that shines in the dark; a main battery of 48 cells; two individual emergency lights, which can be removed, and a switch for testing the light.

Dishwashing Solution Test

• As a part of its service to users of Keego dishwashing solution, the J. B. Ford Company, Wyandotte, Mich., has made available an electrically operated device that determines the strength of the solution in the dishwasher. The instrument, which can be plugged into any 110 volt, 60 cycle A.C. outlet, consists of a dip cell which is immersed in the solution and connected to a pointer that indicates whether the solution is weak, strong or correct.

Hollowware and Flatware

• A new "bayonet" shaped knife blade, designed to permit foods to be cut with greater ease, is presented in the attractive blue and silver brochure recently published by the Gorham Company, Hospital Division, New York City. Numerous other items of hospital silverware are described and illustrated in the booklet.

Keyed Color System

• The O'Brien Varnish Company, Inc., South Bend, Ind., has developed a keyed color system that offers a practical approach to the problem of choosing paint colors. The system consists of a palette of standard wall, ceiling and woodwork tints covering the visible spectrum and keyed for harmony with one another, and a color wheel that shows how to harmonize paint colors with one another as well as with the furnishings in the room.

Paper Cup Package

• A new tube and handy pack designed to facilitate handling and storage of Milapaco jelly dishes has been introduced by the Milwaukee Lace Paper Company, Milwaukee. The package contains 10 tubes of 100 cups each and is said to be of material aid in preventing spoilage of the cups resulting from dust and handling.

Waterproofing Buildings

• A waterproofing material that was originally designed for airplanes has been adapted to use on buildings. The material, which is transparent, is made of nitrocellulose, lacquer, oils and solvent. The Flexrock Company, Philadelphia, is the manufacturer.

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SUNFILLED pure concentrated ORANGE and GRAPEFRUIT JUICES

establish a milestone in processing, packaging and quality achievement. They are true-to-fruit products at their best. Every food element and characteristic, natural to freshly squeezed Florida orange and grapefruit juices, are successfully captured and retained without recourse to adulterants or added preservatives.

Only a percentage of the normal water content has been temporarily borrowed . . . which, when returned by you, insures the same delicious flavor and consistency which Nature endowed.

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COMPARE THESE TYPICAL ANALYSES
(Note vitamin C retention)

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Moisture	24.0	89.7
Total Solids	76.0	10.3
Ash	2.7	0.4
Protein	3.5	0.5
Reducing Sugars	26.0	3.5
Sucrose	31.3	4.3
Carbohydrate (by difference)	63.3	8.6
Citric acid	6.5	0.85
Calories	2.67 per gm. 76. per oz.	.03 per gm. 10. per oz.

Vitamins—Concentrate: 2.5 mg. ascorbic acid (50 international units Vitamin C) per gram. Concentrate diluted with water (1:9) 680 international units Vitamin C per 100 c.c. or 200 international units per fluid ounce.

Complimentary trial quantities to institutions on request.

REDUCE YOUR COST-PER-SERVING TO AN UNPRECEDENTED LOW

There are no fluctuating market prices to consider . . . no unpredictable variations in flavor and consistency . . . no spoilage, shrinkage or waste disposal problems . . . no excessive demands on refrigeration facilities . . . only negligible storage space needed.

Try SUNFILLED and *taste* the difference
Buy SUNFILLED and *save* the difference

CITRUS CONCENTRATES, INC.
Dunedin, Florida

Theoretically and Practically you reach your Objectives WITH Ideal FOOD CONVEYOR SYSTEMS

- **Normal moisture and palatability of food maintained by Ideal automatic temperature control. Dual lights guide attendant.**
- **Effortless handling of unit provided by scientific load distribution and wheel placement, assuring perfect balance.**
- **Absolute rigidity of top deck entirely assured by patented bridge-type assembly of food wells and heating elements.**
- **Easy cleaning inside and outside made possible by rounded, seamless, unobstructed corners.**
- **Convenient, speedy handling of trays and equipment assured by greater shelf area.**
- **Extra and double meat tray capacity afforded by slide-easy warming drawer which holds standard utensil.**
- **Smooth, rigid, all-welded body construction. Long life, good appearance.**
- **Full Underwriters' approval.**

No need to compromise between what you want and what you can get when you use Ideal equipment. Food service with Ideal measures fully up to your most exacting theoretical standards. The essentials of perfect service are *built in* the unit, not dependent upon outside factors, hence always are constant.

Available in a wide range of prices, Ideal Conveyors also meet every budget necessity. All exclusive Ideal features are present in every unit, the price variation depends only on materials employed. Big volume production assures lowest cost and price in the industry. Years of specialization, research and engineering have developed and perfected these exclusive, valuable features at the left.

WRITE FOR FOOD SERVICE ANALYSIS BLANK AND DETAILED SPECIFICATIONS

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Washington Cycle & Supply Co., Seattle, Wash. • In Canada: The Canadian Fairbanks-Morse Co.

Books on Review

THE NEWER NUTRITION IN PEDIATRIC PRACTICE. *By I. Newton Kugelmass, B.S., M.A., Ph.D., Sc.D. New York: J. P. Lippincott Company,* 1940. *Pp.* 1098. $10.

This is one of the few books available that contains detailed information devoted to nutrition in health and disease for children. It is divided into three units. The first deals with nutritional physiology and the importance of providing for proper growth of the child's body, as well as its maintenance and repair.

Unit two, on nutrition in health, discusses methods for the growth and advancement of health, including detailed formulas and normal diets.

Unit three is devoted to nutrition in disease and discusses in detail nutritional disorders of children and their dietary treatment. The author points out the fact that each therapeutic diet is, or should be, a modification of the normal diet. Numerous calculated diets for each disease are included also.

Throughout the book, the author gives the impression that the goal in nutrition is the same for all infants and children but that the methods of attaining it differ with each infant or child.—BEATRICE DONALDSON.

CYCLOPROPANE ANESTHESIA. *By Benjamin Howard Robbins. Baltimore: The Williams Wilkins Co.,* 1940. *Pp.* 175. $3.

This book is not a clinical text, as the title would suggest, but rather an excellent review of the available publications concerning cyclopropane.

Its neat and orderly arrangement, starting with the physical and chemical properties of the drug, followed by the effects on each of the systems and ending with a consideration of the complications, indications and contraindications, makes the book valuable from a reference standpoint. It is important, however, that the reader should not expect it to be a guide to the clinical administration of cyclopropane. The author has quoted many anesthetists but has not had experience with the clinical administration of the drug and, therefore, must not be taken as a clinical authority. He should, however, be complimented on his ability to digest the statements of clinicians in an unprejudiced manner.

His own extensive laboratory researches with cyclopropane have been most valuable and the compilation of his own personal work, together with that of others, serves a most useful purpose. To the initiated, it would appear that, in spite of the rather enthusiastic tone of this monograph, much more extensive investigation is indicated before we can come to a reliable evaluation of cyclopropane as a clinical anesthetic agent.—R. M. WATERS, M.D.

THE NEW YORK HOSPITAL HANDBOOK OF APPLIED NUTRITION. *New York: Secretary, Department of Nutrition, New York Hospital.* 1939. *Pp.* 136. $2.

This handbook gives a number of varied diets. The dietary standards to meet nutritional needs are the basis for the normal and therapeutic conditions and diseases. The exceptional as well as the more common diets are enumerated, along with certain formulas, tonsillectomy and postoperative routines.

The appendix contains test procedures, the vitamin contents of foods, the percentage composition of foods and height-weight tables.

Dietitians will find this a good reference manual, compact and usable.—DOROTHY DEHART.

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Reader Opinion

Controversy Continued

Sirs:

In your April 1940 issue, on page 76, Myers, Harrington and Streukens published a paper on "Minneapolis Seeks a Foolproof Tuberculosis Technic."

The article outlines the technic used and the plan followed and states: "The percentage of those who became tuberculin reactors on our service, including four who may have become infected after leaving it, is only 11.2 per cent. Boynton found in a similar service in another institution that 22.2 per cent were infected."

The tuberculosis service at the Minneapolis General Hospital occupies one floor in the contagious unit. The nurses are assigned to the contagious unit for six weeks but they do not spend more than two weeks of that time on the tuberculosis floor. Moreover, not more than half the beds on this floor are set aside for the care of tuberculosis and at times there have been as few as two tuberculosis patients on the whole floor. Because of that the nurses who are assigned to this floor cannot spend more than half their time in the care of the tuberculous. Furthermore, according to information which I consider reliable and unbiased, nurses who have completed their two weeks on Station M (the tuberculosis unit) are not sent back to this particular floor for relief work.

Thus, the tuberculosis service at the Minneapolis General Hospital is the equivalent of not more than one week's service in a tuberculosis sanatorium, while the institution surveyed by Boynton has a six week's tuberculosis service. Thus, the similarity of the two services rests in the character of the service, but the length of the service in the institution surveyed by Boynton was six times that of the service at the Minneapolis General Hospital.

In another article Myers claims that the incidence of infection is roughly proportionate to the length of exposure. Accepting that statement as true, we can then multiply 11.2 per cent, the increase in the percentage of positive tuberculin reactors following one week's exposure in a tuberculosis service in the Minneapolis General Hospital, by six, representing the six weeks' contact in the institution surveyed by Boynton. This results in a six weeks' infection rate of 67.2 per cent in contrast to 22.2 per cent in the institution surveyed by Boynton.

That is a fantastic infection rate, one which I am sure would not occur even if the tuberculosis service at the Minneapolis General Hospital was six weeks instead of the equivalent of one week. But, I think it calls our attention to two things that are very important in scientific medicine. First, it is manifestly unfair and unscientific to compare the rate of increase in infection resulting from one week's exposure on a tuberculosis service with that resulting from six weeks' exposure. Second, the contagious technic employed at the Minneapolis General Hospital is no more effective in preventing transmission of infection from patient to nurse than is the technic used in the institution surveyed by Boynton.

This article is devoted entirely to contagious technic and omits all reference to vaccination. I know of no other communicable disease in which hospital authorities believe that contagious technic alone will provide all the protection the nurse needs.

Evidence is gradually accumulating to indicate that the tuberculin positive nurse develops tuberculosis much less frequently and with much less severity during training than does the nurse who was tuberculin negative when she began her training.

Furthermore, Heimbeck has conclusively demonstrated that the tuberculin negative nurse who becomes tuberculin positive after vaccination with BCG has almost as much immunity as the nurse who was tuberculin positive at the beginning of training.

In 1936, Kayne reported that if all the disease that occurred in the 1,343,000 infants vaccinated with BCG could be proved to be due to the vaccination, the ratio of tuberculous deaths would be less than one in 15,000 children vaccinated.

Thus, the value of BCG has been proved through Heimbeck's work and its safety through the work of numerous investigators throughout the world. Because of that I cannot understand why hospital authorities deny the tuberculin negative nurse the added protection that vaccination with BCG gives. But they do and they apparently consider that contagious technic will give the tuberculin negative nurse all the protection she needs. Contagious technic alone is considered insufficient protection in other communicable diseases. Why should it be considered sufficient in tuberculosis?

I look forward to the day when the hospitals of the United States will adopt the policy so prevalent throughout Norway, Sweden and Denmark, where tuberculin negative nurses and other tuberculin negative hospital employes are vaccinated with BCG.

E. S. Mariette, M.D.
Superintendent.

Glen Lake Sanatorium,
Oak Terrace, Minn.

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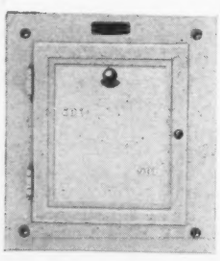

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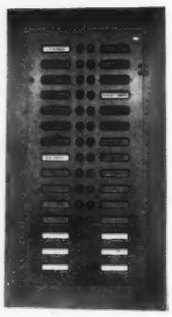

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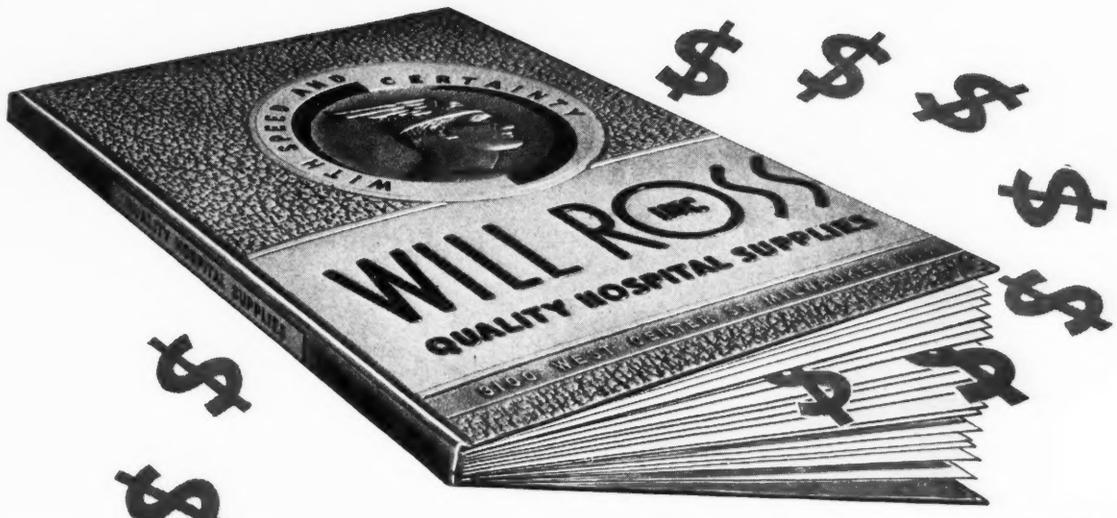

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Reply by Doctor Myers

We note with interest Doctor Mariette's presentation of the detailed activities of the student nurses on our service and, particularly, the statement that his information is from a source that he considers reliable and unbiased. We did not realize that it is possible to find a more reliable or unbiased source of such information than the nurse who has been in charge of the contagious disease unit for many years and has always taken a keen interest in the protection of her students against contagious diseases. Her sincerity, veracity and honesty are beyond question. It was she who prepared that section of our manuscript that deals with the activities of the nurses in reference to contact with tuberculous patients. Doctor Mariette's statement is far from coinciding with her description of the service. Moreover, the medical staff has kept a close watch over this service with particular reference to the protection of students and is in complete disagreement with the statement of Doctor Mariette, who, so far as we know, has never been on the floor since the service began.

In our report we were willing to take all possible blame for students who became reactors; therefore, we added to the six, whom we felt sure became infected on the service, four others concerning whom there was much question because they were exposed to tuberculous patients without contagious disease technic after they left our service and before the final tuberculin test was administered. If we had deducted these four, as we would have a perfect right to do, the percentage of those who became infected on our service would have been 6.6 instead of 11.2.

Doctor Mariette's statement would lead one to feel that student nurses in his sanatorium are constantly in contact with contagious cases, yet elsewhere he claims to have kept a patient there for approximately nine months without having her in contact with open cases, even though for a part of this time she occupied a bed in a sizable ward.

During the period over which we reported the activities of our service, the daily average was 6.4 patients, yet Doctor Mariette emphasizes that on the occasional day there were only two patients, without mentioning that at other times there were as many as 15 patients on the service. It should also be emphasized that while a part of our patients are cooperative and considerate of others, we deal to a considerable extent with patients of the incorrigible type, *i.e.* persons who have been committed to our service by the health department, some of whom have actually been brought in by the police because of their refusal to protect others against their disease. Several have been transferred from the jail or the workhouse, where they were found to have tuberculosis while serving sentences for various offenses. We have considered this an extremely important service to the community from the standpoint of tuberculosis control. At the same time we are cognizant of the fact that we are dealing with a serious problem in protecting our student nurses against the disease of such patients. I have actually seen one patient do more to expose our student nurses within an hour than one would expect to occur from a cooperative patient in several months.

Therefore, from the statement of our chief nurse, together with the observations of the medical staff, linked with the type of patient with which we have to deal, we are of the opinion that there is as much exposure to our student nurses as occurs on Doctor Mariette's service and, thus, the comparison is a fair one.

In our article we emphasize the fact that we do not consider our technic perfect but that we are greatly pleased with the results to date.

If we had a safe immunizing agent 50 per cent as effective as those for smallpox and diphtheria, most certainly we would recommend it for our student nurses. BCG (Bacillus Calmette-Guerin) has been in use for approximately sixteen years but to date there is no evidence, including many times the references Doctor Mariette mentions, that satisfies us as to its efficacy. The veterinarians of the United States and Canada used it in perfectly controlled experiments but found that the cattle which they attempted to immunize developed tuberculosis as frequently and in as severe forms as the controls; therefore, they discarded it. Since our veterinarians will not use this substance in cattle, one could hardly expect us to use it as an experiment on our student nurses.

The medical profession is not slow to accept any immunizing or therapeutic procedure of proved efficacy. Witness the universal acceptance of methods of immunization against smallpox, diphtheria and typhoid fever; witness the prompt and universal use of insulin and liver extract.

Doctor Mariette mentions "that dangerous primary stage" in tuberculosis. To us, this conception of primary tuberculosis in adults as well as children has become almost obsolete. We have observed many hundreds of children with primary tuberculosis and have yet to see one who had serious clinical manifestations. Moreover, we have observed more than 700 young adults who have become infected with tubercle bacilli while under our observation but not one has had significant clinical manifestations from primary tuberculosis, per se. Therefore, in our experience, the primary phase of the development of tuberculosis is extremely benign. However, we are cognizant of the remote dangers of chronic tuberculosis among those who have become infected with tubercle bacilli yet there is not one iota of evidence that BCG or any of the dozens of other alleged immunizing agents that have ever been used have any effect whatsoever in the prevention of these remote developments.

J. A. Myers, M.D.

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